# APPENDIX H

# A Review and Analysis of the Federal and State Laws and Regulations Applicable to Consumer Grievance Oversight of HMOs and Other Managed Care Organizations

**Prepared by the Virginia Department of Health**
**August 20, 1997**

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## I. EXECUTIVE SUMMARY

This paper provides a review and analysis of federal and state statutes and regulations governing grievance protections for consumers in managed care plans. While it focuses on health maintenance organizations, attention is given also to other forms of managed care such as preferred provider organizations.

This review and analysis was undertaken in response to the directive of House Bill 2785 passed by the 1997 Virginia General Assembly to study the quality of care mechanisms in place for HMOs and, in particular, to assess the sufficiency of these mechanisms to provide health care consumers with a means of having their inquiries and complaints addressed. The focus of the analysis is devoted to public oversight and statutory and regulatory authority; examination of HMO internal quality and grievance protections is a separate chapter of the HB 2785 study .

Among the most significant observations of this paper are the following:

ERISA plans, those health plans that are self-funded by employers, are exempt from state oversight and regulation. Thus, state statutes and regulations addressing managed care protections will have no effect on individuals in ERISA plans. The number of people so affected is considerable; the Joint Commission on Health Care has estimated that one third of privately insured individuals are covered by ERISA plans. The U.S. Department of Labor (DOL) has oversight authority for ERISA plans. DOL does not have authority to intervene in beneficiary grievances or to resolve disputes, but may provide individual assistance in the form of advising beneficiaries of their rights under ERISA, and providing general information regarding how federal law may apply to a beneficiary's situation. While ERISA preempts many state laws, DOL has attempted to assist states' consumer protection efforts. A recent collaboration between the Department of Labor and Oklahoma's Department of Insurance to permit the state to monitor complaints about self-funded plans may provide a useful model for other states.

The HB 2785 Consumer and Provider Focused Roundtables, as well as managed care complaints received by the Virginia State Corporation Commission's Bureau of Insurance

and the Virginia Department of Health, indicate that many consumers and providers are confused about how to appropriately grieve an action of an HMO. Repeated reference is made to the need for assistance in "navigating the system." These agencies also receive requests for information and education. Consumers may need assistance and education in order to effectively bring their concerns to their HMOs. This study suggests that an appropriate role for VDH may be that of an educator and facilitator, similar to the Department of Labor's role with ERISA consumers.

HMO grievance protections are found in statute in two chapters of Title 38.2 of the *Code of Virginia*: Chapter 43 contains requirements for HMO grievance systems, and Chapter 54 contains requirements for a particular type of grievance protection, grievances concerning an insurance company's utilization review or medical necessity decisions. The latter type of grievance is perhaps the most important consideration for providers and consumers. There are also state and federal statutes that establish grievance protections for Medicaid HMO enrollees. In the *Virginia Administrative Code*, Section 12 VAC 30-120-420 establishes grievance protections for Medicaid clients enrolled in HMOs. Additionally, the *Code of Federal Regulations* at 42 CFR 434.32, establishes grievance protections for Medicaid clients enrolled in HMOs. The analysis in this paper points out inconsistencies in the requirements for grievance protections under Chapter 43 and Chapter 54. It also identifies a potential need for clarification in the language of Chapter 54. Most importantly, the paper suggests a possible role for the Department of Health with regard to the regulatory oversight of Chapter 54 appeals. The Bureau of Insurance lacks regulatory authority for this oversight function, as well as the medical expertise to perform this function.

Consumer complaints about their HMOs may reach a variety of state agencies. State employees' complaints are handled by the Department of Personnel and Training; the Department of Medical Assistance Services handles complaints from Medicaid clients; the Bureau of Insurance manages consumer complaints about all insurance plans; and the Department of Health, through an interim Memorandum of Agreement with the Bureau of Insurance, handles complaints about the quality or accessibility of care. Additionally, the

Department of Health Professions handles complaints about practitioners. There is currently no mechanism among these agencies for sharing complaint data so there is no organized quality improvement effort aimed at analysis and monitoring of complaint data. This paper offers options for the State Health Commissioner to consider, which include a uniform complaint classification system and a complaint data sharing mechanism. (Any data sharing efforts will be subject to client confidentiality limitations).

Although the Bureau of Insurance and, more recently, the Department of Health, have the authority to investigate complaints on behalf of consumers, neither has the ultimate adjudicatory authority to mandate a remedy for the individual. Individuals would seek such remedies in court, but under Virginia law, a claimant cannot seek punitive damages. The Department of Medical Assistance Services (DMAS), however, does have this authority in that any grievance decision issued by a Medicaid HMO may be appealed by the client to DMAS in accordance with DMAS' Client Appeals regulation at 12 VAC 30-110-10. The DMAS decision in these matters is final and is not subject to any appeals.

The grievance protections found in Chapter 43 of Title 38.2 of the *Code of Virginia* do not apply to forms of managed care other than HMOs, or to indemnity plans. Although Chapter 54 includes all forms of health insurance, it addresses one type of grievance only: denial of coverage for care. The statutes and regulations do not otherwise mandate a grievance system for any type of health insurance other than a health maintenance organization for grievances other than denial of coverage. Public attention could focus on other forms of managed care. It should be noted that DMAS' Client Appeals regulations (12 VAC 30-110-10 et seq.) are afforded to all Medicaid clients, regardless of whether they are enrolled in a Medicaid HMO, in Medallion I (a non-HMO managed care program), or in fee-for-service.

## II. INTRODUCTION

Growing enrollment in HMOs and other managed care organizations has evoked increasing concern that financial incentives inherent in managed care may adversely impact access to quality health care. Recently, independent review of unresolved enrollee and provider grievances against managed care entities has emerged as a pressing consumer protection issue. This issue has been raised in House Joint Resolution 67, subsequent discussion by the Joint Commission on Health Care (JCHC, 1996), by participants in the Virginia Department of Health (VDH) August 1996 Roundtable, in legislation recently enacted by the General Assembly (HB 2785), and by other states across the nation. In addition, anecdotal evidence from consumer advocates and providers suggests that HMO internal grievance systems may be confusing, and that self-interest may preclude an objective review of consumer grievances.

An ombudsman program and an external appeals process have been proposed in HB 2785 as options for addressing independent review of enrollee grievances. An ombudsman may be defined as one who investigates complaints made by consumers, reports findings, and attempts to achieve equitable solutions (Webster's Ninth New Collegiate Dictionary, 1985). An ombudsman is foremost a fair and impartial investigator, but may maintain other roles, such as educating consumers and advocating on their behalf (see box). Various sources, both anecdotal and empirical, regarding managed care consumer disputes suggest that, for a considerable proportion of enrollees, complaint resolution involves education about their plans, assistance with navigating the internal grievance system, or advocacy with their plan on their behalf.

**Ombudsman Models**

By definition, an ombudsman is a fair and impartial investigator. However, an ombudsman can maintain other roles as well. For purposes of this study, the following basic roles will be used as a reference for the ensuing discussion.

**1) Educator/Facilitator**: The ombudsman's role is to help consumers to understand their rights and responsibilities under their plans.

**2) Mediator**: The ombudsman attempts to resolve individual grievances by functioning as a fair and impartial intermediary between the enrollee and his or her plan.

**3) Advocate**: When it is determined that the consumer has cause, the ombudsman attempts to resolve the individual grievance in favor of the enrollee by communicating with the managed care plan on the enrollee's behalf.

The second option proposed in HB 2785, an external appeal process, may provide for grievance investigation, review of findings, resolution by a public or private entity and/or adjudication. Such reviews may be binding or non-binding on a managed care organization. Some consumer advocates favor an external appeal process that provides adjudicatory authority to a public entity. Under such authority, a hearing is conducted to consider all evidence, and an enforceable decision is made. Another variation of external review may involve a non-binding determination made by a public or private entity. Alternatively, a private entity could investigate a dispute and make a recommendation to the public entity with oversight authority, and the public entity would issue a binding or non-binding decision. An external appeal process would, of necessity, limit cases to written grievances that have exhausted the HMO internal appeals process, and so are likely to address a much smaller proportion of total complaint volume. Though compatible with each other, the ombudsman program and external appeal process may differ in the types of consumer disputes they most effectively address. For example, an external appeal process may be appropriate for an enrollee whose written grievance has been through the HMO's internal grievance system, but who thinks the unfavorable decision may have been made inappropriately. In the same situation, an ombudsman could become involved in the role of advocate for the enrollee, by facilitating reconsideration or persuading the HMO to reverse the adverse decision. Or, the ombudsman could serve as impartial mediator. However, it might be inappropriate for a private or public entity to independently review and rule on a consumer complaint that had never been submitted to the HMO for consideration. For such a complaint, the Educator/Facilitator Model would be more effective, with the ombudsman providing assistance to the enrollee on how to access the HMO's internal grievance system.

**External Appeal Process**

An external appeal process may provide for grievance investigation, review of findings, adjudication, and resolution by a public or private entity.

HB 2785, which was signed into law by the Governor on March 21, 1997, directs the State Health Commissioner to consider whether special consumer protections are needed beyond those that exist in current law. In particular, the new law instructs the State Health Commissioner: 1) to consider the appropriate types and sources of complaints admissible within a managed care grievance

oversight system (excluding "purely contractual" complaints); 2) to assess the state's oversight of alleged violations of applicable laws or regulations, including enforcement when appropriate; 3) and to evaluate whether a mechanism to adjudicate issues alleging violation of applicable laws or regulation should be established. These assessments are related to an additional request: 4) to "evaluate whether there is a need to establish an external appeals or ombudsman process for resolving consumer complaints regarding managed care plans," and depending on the judgment of that examination, "whether the Department of Health or another entity should administer the process." ( §38.2-4319(C)(2)(iv) of the *Code of Virginia*)

This paper will examine some of these four directives, and set the groundwork to address the other directives later. The general method presented involves a review of the existing systems for overseeing consumer protections for managed care, including, but not limited to, HMOs. The HB 2785 Study Group determined that it is axiomatic that any new processes to be established should treat all managed care plans—if not all health plans—fairly. Finally, to the extent possible, this study will analyze existing complaint data when available, evaluate their adequacy for making valid judgments, and include suggestions for improved data collection.

## III. OVERSIGHT FOR GRIEVANCE PROCEDURES

The general public and state officials have become more aware of existing grievance-type protections for the consumer of managed care products, particularly HMOs. This increasing awareness has come about slowly, and may be due in part to the variability in grievance systems and their regulation across health plans. The manner in which grievances are handled depends on two factors—the type of health plan, and the type of organization underwriting the plan. Plan types include traditional indemnity insurance (fee for service), HMOs, PPOs, and other managed care products. Entities underwriting plans may include Medicare, Medicaid, commercial insurers, and self-insured employers. These in turn determine the grievance process through the regulatory authorities having jurisdiction over the various plans. Table 1 summarizes these health plans and the regulatory authorities that oversee them; a more detailed discussion of each follows. In addition, a description of the role of the Office of the Attorney General (OAG) in grievance action is included.

While the OAG's office has no direct oversight responsibilities relating to individuals with complaints, it does handle major cases affecting numerous consumers.

**Table 1: Health Plan Oversight by Type**

| Health Plan Type | Entity with Oversight Authority for Grievances/ Complaints | Detailed Grievance/ Complaint Procedures Specified? |
|---|---|---|
| ERISA self-insured plans | U.S. Dept. of Labor (DOL) | Reporting and disclosure, claims procedures |
| | Federal Courts | Court decisions |
| ERISA fully-insured plans | See "Commercial Insurance" below | |
| Commercial Insurance: | | |
| HMOs | Bureau of Insurance (BOI) | *Code of Virginia* |
| | Dept. of Health (VDH) | *Code of Virginia* (quality complaints against providers) |
| | Dept. of Health Professions (DHP) | *Code of Virginia* (complaints against practitioners) |
| All health insurance carriers | BOI | *Code of Virginia* |
| | DHP | *Code of Virginia* (complaints against practitioners) |
| Medicaid: | | |
| HMO (Options II and Medallion II) | Health Care Financing Administration (HCFA) | |
| | Dept. of Medical Assistance Services (DMAS) | Formal appeals process; toll-free recipient assistance line |
| | BOI, VDH and DHP | As with commercial insurance |
| All other, including Medallion I (gatekeeper) | HCFA | |
| | DMAS | Toll-free recipient assistance line |
| | DHP | Complaints against providers |

| **Table 1: Health Plan Oversight by Type** | | |
|---|---|---|
| **Health Plan Type** | **Entity with Oversight Authority for Grievances/ Complaints** | **Detailed Grievance/ Complaint Procedures Specified?** |
| Medicare: | | |
| HMOs | HCFA<br>BOI, VDH and DHP | Oversight authority granted to PROs<br>As with commercial insurance |
| All other | HCFA<br>BOI and DHP | Oversight authority granted to PROs<br>As with commercial insurance |
| State Employees' Benefit Program: | | |
| Self-insured plans | Dept. of Personnel and Training (DPT) | Executive appeal |
| HMOs | DPT<br>BOI and VDH | Executive appeal<br>As with commercial insurance |

**U.S. Department of Labor and Federal Courts: Oversight of ERISA Plans**

The Employee Retirement Income Security Act (ERISA) of 1974, while primarily focused on requirements for employer-based pension plans, also established requirements for employee benefit plans, including health plans. ERISA governs all self-funded private sector health plans; however, federal, state and local government employee plans, as well as church-sponsored plans, are exempt from ERISA. In 1995, approximately 32.5 million nationally were covered under these plans. In Virginia, approximately 35% of the population is covered by an ERISA plan.

The original Act contains the preemption clause through which ERISA supersedes state laws that relate to employee benefit plans. It was intended to allow employers operating in multiple states to offer standard health benefit plans to their employees without having to comply with regulations of the various states in which they conduct business. Because of ambiguities in wording of the initial Act, the federal court system has played a pivotal role in defining the scope of ERISA preemption (U.S. GAO, 1995). As a result, states may regulate insurance carriers and their policies but not employers' plans. Therefore, ERISA plans that are insured by commercial carriers are subject to state regulation and mandated benefits. Self-insured plans are exempt from state insurance laws; oversight authority for these plans rests with the U.S. Department of Labor (DOL).

As a result of judicial interpretations of ERISA, states are prohibited from:

- establishing minimum guaranteed benefits packages for all employers;
- requiring all health plans to provide states with information crucial to developing a comprehensive understanding of the status of the state's health care access and delivery systems;
- establishing a statewide employer mandate;
- imposing a level playing field through premium taxes on self-insured plans; and
- overseeing quality in self-funded health plans and establishing consumer protections.

(Source: National Governors' Association report on Private Sector Health Care Reform, 1997)

Grievance requirements of ERISA plans include disclosure of the grievance procedure in the summary plan document, the provision of a full and fair review of claims, and written notification to a beneficiary or subscriber whose claim has been denied. A claim denial notice must include the reason for the denial, and must be written in terminology understandable to the beneficiary. In addition, the beneficiary must be provided the opportunity to appeal the adverse decision to the fiduciary of the plan. If the adverse decision is reconsidered but not reversed, the beneficiary has limited recourse through the Department of Labor (DOL), as well as through federal court.

ERISA requirements can be classified as follows:

**Reporting and disclosure** requirements specify that plans must regularly report information on participants and finances to DOL. They must also disclose benefits, rights, responsibilities and other plan information to plan participants through a summary plan document.

**Fiduciary standards** encompass the investment and management of plan assets.

**Claims procedures** insure that plan participants and beneficiaries have remedies for violations of ERISA requirements, and are informed of these procedures.

(U.S. GAO, 1995)

***U.S. Department of Labor:*** The DOL does not have authority to intervene in beneficiary grievances or to resolve disputes, but may provide individual assistance in the form of advising beneficiaries of their rights under ERISA, and providing general information regarding how federal law may apply to a beneficiary's situation. A 1995 General Accounting Office report notes that the DOL investigations of employer health plans are, in general, focused at the system level, and do not provide the level of individual complaint investigation provided by state insurance regulators (GAO, 1995).[1] The GAO also reports that, according to the National Association of Insurance Commissioners, ERISA does not provide for an unbiased review process external to the health plan, as state insurance regulators may provide.

*Observation 1: The DOL may not provide, in general, the level of individual protections offered by states. However, it appears to offer some individual protections that the Virginia Department of Health (VDH) does not provide with regard to quality complaints. VDH does not currently provide individual assistance in the form of advising enrollees, members and subscribers of their rights, nor information regarding how state law may apply to a complainant's situation, as the DOL provides with regard to federal law. Medicaid clients are provided with individual assistance through the DMAS helpline and through the Enrollment Broker (Benova). Further, DMAS clients are provided with information regarding how state law may apply to them, in that at the time of enrollment and at the time of any adverse actions taken, Medicaid HMOs are required to notify clients in writing as to their rights under DMAS' Client Appeals regulations.*

**ERISA Plans: Recourse Through Federal Courts**

A suit brought against Xerox Corporation by an employee in December 1991 was tried in September 1996. A senior judge in the U.S. District Court for the District of Connecticut delivered a Decision and Order against Xerox and its plan administrator for "arbitrary and capricious" behavior in denying payment for hospitalization to an employee. In this case, the managed care advisory firm hired by Xerox to control mental health care expenditures had denied payment for all but the first month of the employee's 4-month hospitalization. The court maintained that the plan administrator, by not providing an objective review of the beneficiary's claim, did not uphold her fiduciary responsibility to provide "a full and fair review" of denied claims as stipulated by ERISA. In speaking of the plan administrator's violation of her fiduciary duties, the court observed that "she made no independent effort to determine whether that decision was correct, she did not speak to (the employee) or her psychiatrist, she did not look at the medical record, and did not even consider seeking the advice of a third party." (Business Wire, 1997) The claim has been remanded to Xerox for a fair hearing and reconsideration.

***Federal Courts:*** Plan beneficiaries may

[1] Currently, DOL's system-level protections do not include the classification and analysis of incoming complaint calls by type. In a recent teleconference, DOL Assistant Secretary Olena Berg reported that DOL receives approximately 50,000 calls per year relating to health plans, the majority of which relate to COBRA coverage. In her answer to a Virginia Department of Health question regarding complaint classification, Assistant Secretary Berg reported that DOL does not currently capture that data, but is interested in improving data collection efforts aimed at systematic analysis of complaints against ERISA health plans (Berg, 1997).

also take unresolved disputes to federal court, but, here too, remedies are limited. While a claimant may prove that ERISA requirements have been violated, and thus receive the improperly denied benefit, the claimant cannot be awarded damages. For example, if the outcome of the "fair hearing and reconsideration" of the case in the nearby text box favors the claimant, she will be awarded the denied benefit and her attorney's fees. However, she cannot receive damages for "the months while in the hospital and year agonizing over a mounting debt created by case management's unrelenting pressuring her from afar to leave prematurely" (Business Wire, 1997).

Most states permit damage awards to claimants who were harmed as a result of the denied benefits, providing broader remedies than ERISA. Virginia does not permit damage awards. It should also be noted that ERISA's limited awards may also discourage attorneys from accepting cases on a contingency basis (Dallek, 1995).

***Collaborative Initiatives:*** While ERISA preempts many state laws, DOL has attempted to assist states' consumer protection efforts. DOL has filed "friend of the court" briefs with the intent of limiting the scope of ERISA preemption in areas in which ERISA has been interpreted too broadly. For example, briefs filed in some medical malpractice cases were successful in preventing HMOs from claiming exemption from state malpractice regulations on the basis of their being ERISA plans (Berg, 1997).

Consumers with employer-sponsored insurance are often unaware of the type of plan they have, and so may not know where to go for assistance with grievances. In some cases, plans may be self-funded but use a commercial insurer for administrative services, and consumers may wrongly think that they have commercial coverage with the requisite state protections. In other cases, consumers may understand that their plans are self-insured, but do not realize that the state has no jurisdiction over these plans. In both cases, consumers become aware, and frustrated, when they call the state insurance regulator with a complaint and find that little assistance can be offered at the state level. Moreover, consumers who go on to contact DOL discover that it does not provide the level of individual protections offered by most states. However, a pilot project between Oklahoma's Insurance Department (OID) and the U.S. Department of Labor was recently initiated to better

address individual complaints. The agreement authorizes the Oklahoma Insurance Commissioner to "directly follow up with employers and plan administrators on participant assistance claims they receive dealing with self-funded health benefit plans" that are otherwise exempt from state regulation (U.S. DOL, OID, 1997). Under the agreement, the state may request information from employers and plan administrators regarding complaints, and refer still unresolved complaints to DOL's Pension and Welfare Benefits Administration (PBWA). OID and PBWA will also establish a system for tracking the number and types of referrals. OID gains no new powers, such as legal or investigative authority, from the agreement. The partnership is based on ERISA section 506, which permits the Labor Secretary to enter into cooperative agreements with state and federal agencies. The agreement with Oklahoma is the first state partnership.

> *Observation 2: In Virginia, non-Medicaid consumer complaint calls are most often received by BOI; those relating to ERISA plans are referred to the DOL. ERISA complaint volume is not currently being tracked by BOI.*

**Bureau of Insurance, State Corporation Commission: Oversight of Commercial Carriers**

***System level protections:*** The State Corporation Commission s Bureau of Insurance (BOI) licenses and regulates all insurance carriers. Its major regulatory responsibilities include licensure of plans, licensure of insurance agents, regulation of plan solvency, oversight of marketing, advertising, sales and claims practices, and assurance of compliance with state laws. State requirements regarding complaints against insurance carriers relate to disclosure, claims practices and record keeping.

As part of its market conduct examinations of all insurance carriers,[2] BOI obtains records of all complaints against a carrier since the previous market conduct examination, and reviews these records against BOI's own records of complaints received against the carrier. (The method by which BOI's own records are collected is described in the next section on individual protections.) The examination also includes a review of a statistical selection of complaints to determine if the complaints were handled in a timely manner and in conformance with applicable insurance laws and regulations. In addition to regularly scheduled market conduct examinations, BOI will also conduct targeted examinations when there is evidence of a particular problem, such as an egregious complaint or pattern of complaints.

> **§ 38.2-511. Failure to maintain record of complaints.** — No person other than agents or brokers, shall fail to maintain a complete record of all the complaints that it has received since the date of its last examination under §38.2-1317 or during the last three years, whichever is the more recent time period. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint.
>
> As used in this section, *"complaint"* shall mean any written communication from a policyholder, subscriber or claimant primarily expressing a grievance. (*Code* 1950, § 38.1-52; 1952, c. 317, § 38.1-52.10; 1977, c. 529; 1978, c. 441; 1979, c. 324; 1980, c. 404; 1986, c. 562.)

It should be noted that, while state law contains requirements for complaints and grievances, only 'complaint' is defined in the *Code of Virginia* (Section 38.2-511). 'Grievance' is contained in that definition, but is not further defined.

*Observation 3: The portion of the Code of Virginia applicable to BOI does not adequately*

[2]Section 38.2-1317.1 grants BOI authority to perform market conduct examinations. It states in part: "In scheduling and determining the nature, scope and frequency of examinations, the Commission shall consider such matters as the conduct of business in the marketplace,...".

*define key concepts necessary to the oversight of complaint systems, such as 'inquiry', 'complaint', and 'grievance'. Of the three, only 'complaint' is defined in the Code in Section 38.2-511.*

***Individual level protections:*** BOI's records of health insurance complaints are generated as part of its process of handling inquiries and complaints from consumers regarding all types of insurance carriers. In the fiscal year ended June 30, 1997, the Life and Health Consumer Services Section of BOI handled approximately 3,700 inquiries and complaints against insurance carriers, the majority of which were health insurance complaints. Most of these complaints and inquiries are received from consumers[3] through the State Corporation Commission's toll-free hotline, (800) 552-7945.[4] The menu-driven system directs consumers with insurance concerns, including those relating to health insurance, to the Bureau's Life and Health Consumer Services Section. The role of the Life and Health Consumer Services Section is to communicate with insurers, advocate on behalf of consumers, and facilitate complaint resolution. It does not have authority to adjudicate those complaints which are based upon contractual interpretation, but often serves as an advocate to convince the insurer or HMO to modify its position. The complaint investigation process also serves as a mechanism for identifying violations of insurance laws. If the Life and Health Consumer Services Section determines that insurance laws may have been violated, BOI will so indicate to the carrier as part of its advocacy for the consumer, and may also use its enforcement authority to initiate disciplinary proceedings against the carrier, as appropriate.

The Life and Health Consumer Services Section handles all complaints received until it is able to determine that a complaint is not within its regulatory purview. When it is determined that a complaint is not within the jurisdiction of BOI, the complainant is referred to the appropriate regulatory agency, such as DOL for ERISA complaints. Until recently, complaints involving quality of care in HMOs were pursued to the point where there was a clear difference of medical opinion as to the need for the disputed service. If the insurer or HMO maintained its position, the

[3]The section does not handle complaints from providers, with respect to relationships between providers and carriers. Providers advocating on behalf of patients are asked to have the complaint filed by the person insured.

[4]Section 38.2-305 of the *Code of Virginia* requires this toll-free number and BOI's address to appear on "each *new or renewal* insurance policy, contract, *certificate or evidence of coverage issued to a policyholder, covered person or enrollee*." (HB 2785 modified this section through the addition of the words in italics).

complainant was told that BOI could not resolve the issue in question. New procedures now provide that a complaint be evaluated early in the process, and if it involves quality of care in an HMO, that it is to be referred to VDH. Until recently, few complaints were forwarded, because prior Commissioners of Health did not handle quality of care complaints. More recently, collaborative efforts between BOI and VDH have improved the identification and referral of quality complaints. These collaborative efforts have been captured in an interim Memorandum of Agreement (MOA) between BOI and VDH. Discussion of this MOA, VDH's statutory authority for complaint investigation, and possible reasons for the previously low volume of referrals handled by VDH are included in the description of VDH individual protections below. It should be noted that VDH does not have authority for quality oversight of other forms of managed care. Therefore, when BOI's Consumer Services Section receives a quality complaint involving an insurance carrier that is not an HMO, it is unable to forward the complaint. There is currently no statutory or regulatory authority for VDH to address these complaints.

> *Observation 4: VDH has authority for quality oversight of HMOs, but not for other forms of managed care. Non-Medicaid subscribers and enrollees who call the BOI with quality complaints against managed care plans other than HMOs do not have their complaints addressed by the state under the current system. It should be noted, however, that Medicaid clients in the Medallion program (which is a non-HMO managed care program) do have a process for having their complaints addressed under the current system.*

**Bureau of Insurance, State Corporation Commission: Oversight of HMOs**

***System level protections:*** BOI is granted much of the regulatory authority relating to HMO grievance systems. BOI s authority to regulate HMOs is specified in Title 38.2, Chapter 43 of the *Code of Virginia.* This regulatory authority includes oversight responsibility for enrollee complaint systems. Sections of the *Code of Virginia* relating to grievance systems authorize BOI to: 1) require that a description of the HMO enrollee grievance system be submitted with initial licensing and renewal applications; 2) require that the HMO's complaint system be described in the evidence of coverage[5]; 3) require that the HMO establish and maintain a complaint system for resolution of

[5]The evidence of coverage is defined in the *Code of Virginia* as "...any certificate, individual or group agreement or contract, or identification card issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled." In addition to a description of the grievance system, the evidence of coverage also includes descriptions of the health care services,

written complaints and submit an annual complaint report to the oversight authority; 4) conduct an on-site financial examination of each HMO, including its complaint system, at least once every five years; 5) conduct market conduct examinations of HMOs;[6] and 6) establish "failure to implement a complaint system" as one of the conditions that may lead to suspension or license revocation. The sections of the *Code of Virginia* relating to enrollee grievance systems are excerpted and appear in Table 2. Sections of the *Virginia Administrative Code* relevant to this discussion are detailed in Table 3.

**Table 2: Excerpts from the *Code of Virginia* Relating to HMO Grievance Systems**

**§ 38.2-4301. Establishment of health maintenance organizations.** —
...B. Each application for a license shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commission, and shall set forth or be accompanied by the following:
...10. A description of the complaint system required in §38.2-4308;**…**

**§ 38.2-4306. Evidence of coverage and charges for health care services.** — A.
...4. An evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:
...(e.) A description of the health maintenance organization's method for resolving enrollee complaints. Any subsequent change may be evidenced in a separate document, issued to the enrollee;**…**

**§ 38.2-4308. Complaint system.** — A. Each health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of written complaints. The complaint system shall be established after consultation with the State Health Commissioner and approval by the Commission.

B. Each health maintenance organization shall submit to the Commission and the State Health Commissioner an annual complaint report in a form prescribed by the Commission, after consultation with the State Health Commissioner. The complaint report shall include (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the complaint system, (iii) a compilation of causes underlying the complaints filed, and (iv) the number, amount, and disposition of malpractice claims settled or adjudicated during the year by the health maintenance organization and any of its health care providers. A record of complaints shall be maintained for the period set forth in §38.2-511.

C. The Commission, in cooperation with the State Health Commissioner, shall examine the complaint system. However, at its discretion, the Commission may accept the report of examination conducted by the State Health Commissioner instead of making its own examination.

insurance and benefits to which the enrollee is entitled, limitations on services and benefits (including co-payments and deductibles), information regarding how services are to be obtained, payment information, and conversion rights. A list of providers and a description of the service area is to accompany the evidence of coverage, if not previously given to the subscriber at enrollment.

[6]BOI attempts to conduct a market conduct examination of each HMO licensed in Virginia every 4-5 years, although there is no statutory requirement that this be done within a particular time frame.

## Table 2: Excerpts from the *Code of Virginia* Relating to HMO Grievance Systems

**§ 38.2-4315 Examinations.** — A. The Commission shall examine the affairs of each health maintenance organization as provided for in § 38.2-1317 at least once every five years. The Commission may examine the affairs of providers with whom any health maintenance organization has contracts, agreements, or other arrangements according to its health care plan as often as it considers necessary for the protection of the interests of the people of this Commonwealth.

B. Instead of making its own examination, the Commission may accept the report of an examination of a foreign health maintenance organization certified by the insurance supervisory official, similar regulatory agency, or the state health commissioner of another state.

C. The Commission shall coordinate such examinations with the State Health Commissioner to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

D. The expenses of examinations by or for the State Health Commissioner under this section shall be assessed against the organization being examined and remitted to the State Health Commissioner.

E. Instead of making its own examination, the Commission or State Health Commissioner may accept the report of an examination of a foreign health maintenance organization certified by the insurance supervisory official, similar regulatory agency, or the state health commissioner of the state of domicile. (1980, c. 720, § 38.1-879; 1986, c. 562.)

**§ 38.2-4316. Suspension or revocation of license.** — A. The Commission may suspend or revoke any license issued to a health maintenance organization under this chapter if it finds that any of the following conditions exist:

...4. The State Health Commissioner certifies to the Commission that the health maintenance organization is unable to fulfill its obligations to furnish quality health care services as set forth in its health care plan consistent with prevailing medical care standards and practices in the Commonwealth.

...7. The health maintenance organization has failed to implement the complaint system required by § 38.2-4308 to resolve valid complaints reasonably;**…**

**§ 38.2-4318. License renewals.** — A. Each health maintenance organization licensed under this chapter shall renew its license with the Commission annually by July 1. The renewal license shall not be issued until the health maintenance organization has paid all fees and charges imposed on it and has complied with all other requirements of law....

## Table 3: Excerpts of the *Virginia Administrative Code* Relating to HMO Grievance Systems

**14 VAC 5-210-70 (H) Grievance procedure.**

1. Each health maintenance organization shall establish and maintain a grievance or complaint system to provide reasonable procedures for the prompt and effective resolution of written complaints. A record of all written complaints shall be maintained for a period of at least three years.

2. Every health maintenance organization shall provide complaint forms and/or written procedures to be given to enrollees who wish to register written complaints. Such forms or procedures shall include the address and telephone number to which complaints must be directed and shall also specify any required time limits imposed by the health maintenance organization.

3. The grievance system shall provide for complaints to be resolved within a reasonable period of time, not more than 180 days from the date the complaint is registered. This period may be extended (i) in the event of a delay in obtaining the documents or records necessary for the resolution of the complaint, or (ii) by the mutual written agreement of the health maintenance organization and the enrollee registering the complaint.

4. Pending the resolution of a written complaint filed by a subscriber or enrollee, coverage may not be terminated for the subscriber or enrollee for any reason which is the subject of the written complaint, except where the health maintenance organization has, in good faith, made an effort to resolve the complaint and coverage is being terminated as provided for in subsection B of 14VAC5-210-80 of this chapter.

**Table 3: Excerpts of the *Virginia Administrative Code* Relating to HMO Grievance Systems**

5. Where enrollee complaints and grievances may be resolved through a specified arbitration agreement, the enrollee shall be advised in writing of his rights and duties under the agreement at the time the complaint is registered. No contract or evidence of coverage that entitles enrollees to resolve complaints and grievances through an arbitration agreement shall limit or prohibit such arbitration for any claims asserted having a monetary value of $250 or more. If the enrollee agrees to binding arbitration his written acceptance of the arbitration agreement shall not be executed prior to the time the complaint is registered nor subsequent to the time an initial resolution is made, and the agreement must be accompanied by a statement setting forth in writing the terms and conditions of binding arbitration.

***Individual level protections:*** The Life and Health Consumer Services Section of BOI, handles consumer complaints regarding health insurance carriers, including HMOs.

**Bureau of Insurance, State Corporation Commission: Oversight of Utilization Review Entities**

In addition to grievance system standards and oversight, and complaint investigation management, the *Code of Virginia* also establishes requirements for utilization review (UR) standards and appeals.[7] UR entities subject to Title 38.2, Chapter 54 include HMOs, health insurers, hospital service corporations, health services plans and preferred provider organizations conducting utilization review solely for subscribers, policyholders, members or enrollees.[8]

Chapter 54 does not apply to private review agents; they are subject to Chapter 53, which authorizes BOI to require private review agents to obtain a certificate to practice in the state. Private review agents applying for a certificate must meet certain minimum standards. They must provide descriptions of UR procedures, the patient and provider appeal process, the type and qualifications of personnel employed or contracted, and confidentiality mechanisms. It should be noted that the Department of Health Professions is conducting a study to determine whether UR agents who make prospective medical necessity determinations should be licensed in their professions and be subject to action by the relevant regulatory boards. The study will also consider alternative methods for

[7]As of 1996, Virginia was one of seven states to have implemented such a provision (Families USA, 1996). Since then, at least one other state (Colorado) has implemented UR standards and appeals.

[8]This statute applies to approximately 1,000 utilization review entities conducting business in Virginia.

**§ 38.2-5300. Definitions.** — In this chapter and Chapter 54 (§ 38.2-5400, et seq.) Of this title, the following terms have the meanings indicated:
*"Utilization review"* means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care resources rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, health maintenance organization or other entity or person. For purposes of this chapter and Chapter 54 of this title, "utilization review" shall include, but not be limited to, preadmission, concurrent and retrospective medical necessity determination and review related to the appropriateness of the site at which services were or are to be delivered. "Utilization review" shall not include review of issues concerning insurance contract coverage or contractual restrictions on facilities to be used for the provision of services or any review of patient information by an employee of or consultant to any licensed hospital for patients of such hospital.

assuring professional accountability in prospective medical necessity determinations.

***System level protections:*** The oversight authority established under Section 38.2-5400, et seq. provides for grievance protections at the system level. Under Chapter 54, BOI is granted authority to determine whether a UR entity has complied with requirements to establish standards, to adopt a UR plan and to maintain records. However, BOI does not have authority to adjudicate controversies arising out of Section 38.2-5400, et seq. Chapter 54 is reproduced in Table 4.

**Table 4: Title 38.2, Chapter 54 of the *Code of Virginia***

**§ 38.2-5401. Application to and compliance by utilization review entities—**A. No utilization review entity shall perform utilization review with regard to hospital, medical or other health care resources rendered or proposed to be rendered to a covered person except in accordance with the requirements and standards set forth in this chapter.
B. This chapter shall not apply to utilization review performed under contract with the federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act or under contract with a plan otherwise exempt from operation of this chapter pursuant to the Employee Retirement Income Security Act of 1974.
C. This chapter shall not apply to private review agents subject to Chapter 53 (§38.2-5300 et seq.) of this title.
D. This chapter shall not apply to programs administered by the Department of Medical Assistance Services or under contract with the Department of Medical Assistance Services.

**§ 38.2-5402. Requirements and standards for utilization review entities.**—A. Each entity shall establish standards and criteria to be applied in utilization review determinations with input from physician advisors representing major areas of specialty and certified by the boards of the various American medical specialties. Such standards shall be objective, clinically valid, and compatible with established principles of health care. Such standards shall further be established so as to be sufficiently flexible to allow deviations from norms when justified on case-by-case bases. The entity shall make available to any provider, upon written request, a list of such physician advisors and their major areas of specialty, as well as the standards and criteria established in accordance with this section except as prohibited in accordance with copyright laws.
B. An adverse decision shall be made only in accordance with §38.2-5406.
C. Each entity shall have a process for reconsideration of an adverse decision in accordance with §38.2-5407 and an appeals process in accordance with §38.2-5408.
D. Each entity shall make arrangements to use the services of physician advisors who are specialists in the various categories of health care on "per need" or "as needed" bases in conducting utilization review.

| **Table 4: Title 38.2, Chapter 54 of the *Code of Virginia*** |
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| E. Each entity shall have review staff who are properly qualified, trained and supervised, and supported by a physician advisor, to carry out its review determinations.<br>F. Each entity shall notify its covered persons of the review process, and shall so notify the covered person's provider upon written request by the provider.<br>G. Each entity shall communicate its utilization review decision no later than two business days after receipt by the entity of all information necessary to complete the review.<br>H. Each entity shall have a representative, authorized to approve utilization review determinations, available to covered persons and providers in accordance with §38.2-5404.<br>I. The Commission shall have the right to determine that an entity has complied with the requirement that the entity establish requirements and standards pursuant to this section; however, the Commission shall have no jurisdiction to adjudicate controversies arising out of this section. |
| **§ 38.2-5403. Utilization review plan required.**—A. Each utilization review entity subject to this chapter shall adopt a utilization review plan that contains procedures for complying with the requirements and standards of §38.2-5402 and other applicable provisions of this chapter. Such plan shall contain at a minimum the following:<br>1. Specific procedures to be used in review determinations;<br>2. A provision for advance notice to covered persons of any requirements for certification of the health care setting or pre-approval of the necessity of health care service or any other prerequisites to approval of payment;<br>3. A provision for advance notice to covered persons that compliance with the review process is not a guarantee of benefits or payment under the health benefit plan;<br>4. A provision for a process for reconsideration of adverse decisions in accordance with §38.2-5407, and an appeals process in accordance with § 38.2-5408; and<br>5. Policies and procedures designed to ensure confidentiality of patient-specific medical records and information in accordance with subsection C of §38.2-5405.<br>B. Each utilization review entity subject to this chapter shall make available to providers and covered persons, upon written request, a copy of those portions of its utilization review plan relevant to the specific request.<br>C. The Commission shall have the right to determine that an entity has complied with the requirement that the entity adopt a utilization review plan in accordance with subsection A; however, the Commission shall have no jurisdiction to determine the propriety of such plan. |
| **§ 38.2-5404. Accessibility of utilization review entity.**—A. A utilization review entity shall provide accessibility for covered persons and providers by free telephone at least forty hours per week during normal business hours. Entities located outside of the eastern time zone shall provide covered persons advance written notification of the eastern time zone hours during which those entities are accessible; provided that such hours shall be no less than forty hours per week during normal business hours. The entity shall install and maintain an adequate telephone system that accepts and records messages or accepts and provides recorded business hour information for incoming calls outside of normal business hours.<br>B. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section. |
| **§ 38.2-5405. Emergencies; extensions; access to and confidentiality of patient-specific medical records and information.**—A. For emergency health care, authorization may be requested by the covered person, his representative, or his provider either within forty-eight hours of or by the end of the first business day following the rendering of the emergency health care, whichever is later.<br>B. An entity shall promptly review a request from the covered person, his representative, or his provider for an extension of the original approved duration of health care or hospitalization. If the entity fails to confirm that termination of health care or hospitalization will occur on the original date authorized, the entity shall review retrospectively whether the extension of health care or hospitalization was medically appropriate.<br>C. Each entity shall have reasonable access to patient-specific medical records and information.<br>D. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section. |

| **Table 4: Title 38.2, Chapter 54 of the *Code of Virginia*** |
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| **§ 38.2-5406. Adverse decision.**—A. The treating provider shall be notified of any adverse decision within two working days of the decision. Any such notification shall include instructions for the provider to seek a reconsideration of the adverse decision, including a contact name, address, and telephone number.<br>B. No entity shall render an adverse decision unless it has made a good faith attempt to obtain information from the provider. In any instance in which certification is questioned on the basis of medical necessity, at any time before the entity renders its decision, the provider shall be entitled to review the issue of medical necessity with a physician advisor or peer of the treating health care provider who represents the entity.<br>C. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section. |
| **§ 38.2-5407. Reconsideration of adverse decision.**—A. Any reconsideration of an adverse decision shall be made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor or peer of the treating health care provider on the panel. The treating provider shall be notified of the determination of the reconsideration of the adverse decision, in accordance with § 38.2-5402, including the criteria used and the clinical reason for the adverse decision, the alternate length of treatment of the alternate treatment setting(s), if any, that the entity deems to be appropriate, and the opportunity for an appeal pursuant to § 38.2-5408.<br>B. Any reconsideration shall be rendered and the decision provided to the treating provider within ten working days of receipt of the request for reconsideration.<br>C. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section. |

## Table 4: Title 38.2, Chapter 54 of the *Code of Virginia*

**§ 38.2-5408. Final adverse decision; appeal.**—A. Each entity shall establish an appeals process, including a process for expedited appeals, to consider any final adverse decision that is appealed by a covered person, his representative, or his provider. Except as provided in subsection E, notification of the results of the appeal process shall be provided to the appellant no later than sixty working days after receiving the required documentation. The decision shall be in writing if so requested and shall state the criteria used and the clinical reason for the decision.

B. Any case under appeal shall be reviewed by a peer of the treating health care provider who proposes the care under review or who was primarily responsible for the care under review. With the exception of expedited appeals, a physician advisor who reviews cases under appeal must be a peer of the treating health care provider, must be board certified or board eligible, and must be specialized in a discipline pertinent to the issue under review. A physician advisor or peer of the treating health care provider who renders a decision on appeal shall: (i) not have participated in the adverse decision or any prior reconsideration thereof; (ii) not be employed by or a director of the utilization review entity; and (iii) be licensed to practice in Virginia, or under a comparable licensing law of a state of the United States, as a peer of the treating health care provider.

C. The utilization review entity shall provide an opportunity for the appellant to present additional evidence for consideration on appeal. Before rendering an adverse appeal decision, the utilization review entity shall review the pertinent medical records of the covered person's provider and the pertinent records of any facility in which health care is provided to the covered person which have been furnished to the entity.

D. In the appeals process, due consideration shall be given to the availability or nonavailability of alternative health care services proposed by the entity. No provision herein shall prevent an entity from considering any hardship imposed by the alternative health care on the patient and his immediate family.

E. When an adverse decision or adverse reconsideration is made and the treating health care provider believes that the decision warrants an immediate appeal, the treating health care provider shall have the opportunity to appeal the adverse decision or adverse reconsideration by telephone on an expedited basis.

1. The decision on an expedited appeal shall be made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor on the panel.

2. The utilization review entity shall decide the expedited appeal no later than one business day after receipt by the entity of all necessary information. An expedited appeal may be requested only when the regular reconsideration and appeals process will cause a delay in the rendering of health care that would be detrimental to the health of the patient. Both providers and utilization review entities shall attempt to share the maximum information by telephone, facsimile machine, or otherwise to resolve the expedited appeal in a satisfactory manner. An expedited appeal decision may be further appealed through the standard appeal process established by the entity unless all material information and documentation were reasonably available to the provider and to the entity at the time of the expedited appeal, and the physician advisor reviewing the case under expedited appeal was a peer of the treating health care provider, was board certified or board eligible, and specialized in a discipline pertinent to the issue under review.

F. The appeals process required by this section does not apply to any adverse decision, reconsideration, or final adverse decision rendered solely on the basis that a health benefit plan does not provide benefits for the health care rendered or requested to be rendered.

G. No entity or insurer, health services plan, health maintenance organization or preferred provider organization performing utilization review pursuant to this chapter or Chapter 53 (§38.2-5300 et seq.) shall terminate the employment or other contractual relationship or otherwise penalize a health care provider for advocating the interest of his patient or patients in the appeals process or invoking the appeals process, unless the provider engages in a pattern of filing appeals that are without merit.

H. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

| **Table 4: Title 38.2, Chapter 54 of the *Code of Virginia*** |
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| **§ 38.2-5409. Records.** Every entity subject to this chapter shall maintain or cause to be maintained, in writing and at a location accessible to employees of the Commission, records of review procedures; the health care qualifications of the entity's staff; the criteria used by the entity to make its decisions; review complaints received, including the manner in which the complaints were resolved; the number and type of adverse decisions, and reconsideration; the number and outcome of final adverse decisions and appeals thereof, including a separate record for expedited appeals; and procedures to ensure confidentiality of medical records and personal information. Records shall be maintained or caused to be maintained by the utilization review entity for a period of five years, and all such records shall be subject to examination by the Commission. |

**Comparison of HMO Grievance Provisions: Chapter 43 and Chapter 54**

While managed care consumers theoretically have a multiplicity of issues that they may wish to grieve to their plan, adverse utilization review decisions are among the issues that are the most important to consumers. Whether the health plan has denied a service in advance, or refused to pay for a service after the fact, UR denials are very much at the heart of concerns about managed care protections. In Virginia, an enrollee of a commercial HMO[9] who receives an adverse decision from his plan can appeal the decision through the HMO's grievance system, or through his provider in accordance with the provisions of Chapter 54.[10] HMO grievance systems are addressed in Section 38.2-4308 and in administrative law at 14 VAC 5-210-70. These statutes and regulations address grievances in general and apply to any type of written complaint, including grievances about HMOs' utilization review decisions. On the other hand, the provisions of Chapter 54 specifically address appeals of utilization review decisions. Moreover, Chapter 54 applies not only to HMOs, but also to any insurer, health services plan, or preferred provider organization performing UR internally. The significant differences between UR appeals under Chapters 43 and 54 are discussed below.

***Timeliness of Response:*** Chapter 54 defines an adverse decision as either a decision not to approve a proposed service, or a decision not to approve payment for a service already received. Section 38.2-5406(A) requires that the health plan making an adverse decision notify the treating provider within two days of the decision, and inform the provider of the procedure for requesting a

[9]Chapter 54 is not applicable to Medicare HMOs or to programs administered by the Department of Medical Assistance Services, per Section 38.2-5401( C) and (D), respectively.

[10]Under Chapter 54, the covered person or his representative can appeal a *final* adverse decision.

reconsideration. Section 38.2-5407(B) requires that the health plan notify the provider of the result of the reconsideration within ten working days of the receipt of the reconsideration request. If the health plan decides against the provider, the decision becomes a final adverse decision, and may be appealed by the provider, the covered person, or his representative. Section 38.2-5408(A) requires the health plan to notify the appellant of the results of this appeal no later than sixty working days after receiving any required documentation.

Section 38.2-5408(E) provides for expedited appeals of adverse decisions or final adverse decisions within one business day of receipt by the health plan of all pertinent information. Expedited appeals may be requested by the treating provider when he or she believes that the adverse decision warrants an immediate appeal.

The time frames for response from the health plan in Chapter 54 are significantly shorter than the response time required of the HMO in the insurance regulations. 14 VAC 5-210-70(H)(3) requires that HMO complaints "be resolved within a reasonable period of time, not more than 180 days from the date the complaint is registered." Thus, an HMO enrollee will likely receive a much quicker response to an appeal of a utilization review decision if he appeals the decision in accordance with Chapter 54 rather than using the grievance procedures required by Chapter 43 and the regulations.

***Individual Bringing an Action:*** As currently stated in Section 38.2-5406(A), the UR entity must notify the treating provider of an adverse decision, and "shall include instructions for the provider to seek a reconsideration of the adverse decision, including a contact name, address, and telephone number." Moreover, Section 38.2-5407(A) states that the treating provider is to be notified of the results of the reconsideration request (i.e.,the first level of appeal), and of the opportunity for a second level appeal. Section 38.2-5408(A) states that the appeal of an unfavorable reconsideration, or final adverse decision, may be brought by the HMO enrollee, his representative, or his provider.[11] Section 38.2-5408(E) indicates that a request for reconsideration of an adverse

[11]Section 38.2-5404 and 5405 also explicitly include action by the covered person. Section 38.2-5404(A) requires that the UR entity be accessible to the covered person by telephone at least 40 hours per week. Section 38.2-5405(A) deals with emergency health care, and states that the covered person, his representative, or his

decision or a request for expedited appeal must be made by the treating provider.

There is no specified process for notifying the covered person of the adverse decision, or the reconsideration of the adverse decision. The covered person does not participate in the first level of appeal (the reconsideration of the adverse decision), but does participate in the second level of appeal (of the final adverse decision) if it does not require expedited handling.

With regard to Chapter 43, the insurance regulations prescribing HMO grievance systems address written complaints filed by a subscriber or enrollee only.

***Access to UR Standards and Criteria:*** Section 38.2-5402(A) requires health plans to share UR criteria with *any* provider upon written request provided that copyright laws are not violated. While Section 38.2-5403(B) states explicitly that the UR *plan* shall be made available to covered persons upon written request, there are no provisions in Section 38.2-5402 for sharing UR criteria and standards with enrollees or their representatives.

The requirements for complaint systems in Chapter 43 and in the insurance regulations make no mention of UR criteria.

***Disclosure of Process:*** Section 38.2-4306(A)(4)(e) entitles HMO enrollees to an evidence of coverage containing a description of the HMO's method for resolution of enrollee complaints. There is no requirement that the evidence of coverage contain any information on UR appeals. 38.2-5402(F) requires disclosure of the utilization review process to the covered person, but does not specify the method of disclosure. Section 38.2-5403(B) requires that the UR plan[12] and the appeals process be made available to providers and covered persons upon written request, specifying that it include the "portions of its utilization review plan relevant to the specific request."

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provider may request authorization.

[12]The definition of "utilization review plan" in Chapter 54 is "...a written procedure for performing review."

***Other Process Requirements:*** Chapter 54 requires that health plans provide two levels of appeal: the reconsideration request and the appeal of the final adverse decision. For complaint systems, neither the sections of the *Code* nor the regulations have any requirements regarding the levels of appeal. Additionally, Chapter 54 requires that reconsideration and appeals be reviewed by a peer of the treating health care provider. With respect to requirements for HMO complaint systems, no provisions are made in the *Code* or the regulations regarding the qualifications of the individuals reviewing the member's grievance.

***Health Plan Reporting Requirements:*** Under Section 38.2-4308(B), HMOs are required to submit to the Commissioners of Health and Insurance an annual complaint report that includes a description of the procedures of the complaint system, the total number of complaints handled through the system, a summary of the causes for complaint, and information on malpractice claims settled or adjudicated that were brought against the HMO or any of its providers.

Section 38.2-5409 requires that utilization review entities keep records of utilization review standards and appeals for five years, that these records be accessible to the BOI, and that BOI may examine these records. The law does not require that these records be *submitted* to BOI, if requested. As previously noted, BOI does not have authority to adjudicate controversies arising out of Section 38.2-5400, et seq. BOI requested this language to exclude its involvement in issues of health care quality, and in contractual disputes between a plan and its providers. BOI's position on the former is that such disputes should be pursued in the court system. Regarding the latter, medical determinations relating to quality of care are outside the scope of BOI's insurance regulatory functions.

> *Observation 5: A commercial HMO enrollee wishing to grieve a utilization review decision has significantly different options, depending on whether the HMO grievance system or the provisions of Chapter 54 are used. The latter approach provides for a more rapid response, but requires the advocacy of his treating provider for the first level of the process, the request for reconsideration. Chapter 54 also permits the enrollee a representative. The requirements for HMO grievance systems do not recognize a representative or provider advocate. In addition, Chapter 54 requires a peer of the treating physician to review reconsideration and appeal requests, but no such requirements are in evidence for HMO grievance systems.*

*Observation 6: Utilization review standards and appeal legislation was passed in 1995, and requirements have now been in place for two years. Entities subject to Chapter 54 should now have two years' worth of information on UR review complaints received, their resolution, numbers and types of adverse decisions and reconsideration, numbers and outcomes of final adverse decisions and appeals, and separate records for expedited appeals.*

*Observation 7: Nearly 1,000 UR entities subject to Chapter 54 must make UR records available for review by BOI, but there is no requirement to submit records of utilization review complaints and appeals to BOI, if requested, or to VDH. No analysis of these data has been conducted. Moreover, medical necessity determinations under utilization review may be outside the scope of BOI's insurance regulatory functions.*

**Virginia Department of Health: Oversight of HMOs**

VDH is charged with the responsibility for ensuring that medical care entities provide consumers with at least a minimum level of care according to regulations prescribed by the Board of Health and any additional requirements that may be specified in the *Code of Virginia*. In October 1996, the VDH Office of Health Facilities Regulation was administratively renamed the Center for Quality Health Care Services and Consumer Protection (hereafter called the "Center"). The Center continues to be the licensing agent for VDH. As directed by the *Code of Virginia*, the Board of Health adopts specific licensure regulations pertaining to medical care facilities and services, i.e., hospitals, outpatient surgical hospitals, nursing facilities, home health organizations, and hospice organizations.

Titles XVIII and XIX of the Social Security Act mandate the establishment of minimum health and safety standards which must be met by providers and suppliers participating in the Medicare and Medicaid programs. In order for medical facilities and services to receive Medicaid/Medicare funding, they must maintain compliance with the regulations promulgated by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services.

**The VDH Center for Quality Health Care Services and Consumer Protection has oversight authority for the following:**

**State Facilities/Services/Programs**

Home Care (80)
Hospitals(101)
Hospice (59)
Nursing Facilities (265)
Outpatient Surgical Hospitals (23)

**Selected Providers/Practitioners**

Nursing Facilities (339)
Portable X-Ray (7)
Hospitals (109)
Rural Health Clinics (53)
Home Health (220)
Chiropractors (120)
Hospice (49)
Psychiatric Hospitals (15)
Community Mental Health Centers (7)
Ambulatory Surgical Centers (23)
Clinical Laboratories (3,792)
End Stage Renal Disease Facilities (102)
Comprehensive Outpatient Rehabilitation Facility (10)
Outpatient Physical Therapy/
Outpatient Speech Pathology (113)
Physical Therapy Independent Practice (101)
PPS Exclusion - Psychiatric Units (37)
PPS Exclusion - Rehabilitation Units (19)

The Center inspects and licenses medical care facilities and services, conducts surveys for *federal certification*, conducts Medicaid inspections in institutions for the mentally retarded, and investigates complaints. Federal certification responsibilities include selected practitioners, which are noted in the nearby text box. Both state licensure and federal certification regulations are enforced by medical facilities inspectors who are VDH employees. Inspection activities, the most visible obligation of the Center, are used to satisfy both the state licensure requirements and federal certification requirements. In addition to regulatory compliance inspections, the Center investigates complaints made by the public regarding noncompliance with statutes and regulations. Where possible, the Center tries to administratively investigate complaints. More often, however, an on-site investigation is required to appropriately investigate the allegation. The Center is adapting its experience in facilities regulation to assume the new responsibility of oversight for the quality of care provided by HMOs and, perhaps, by other managed care organizations.

**System level protections:** Some of the HMO oversight responsibilities granted to BOI under Title 38.2 Chapter 43 of the *Code of Virginia* are also granted to the State Health Commissioner. Section 38.2-4308(A), which grants BOI the authority to approve enrollee complaint systems, also requires HMOs to consult the State Health Commissioner in establishing their complaint systems.[13] HealthCommissioner, *shall* conduct examinations of Section 38.2-4308(B) requires HMOs to submit their

[13]The mechanism for this consultation may not currently be clear to HMOs. Standardizing it and making communications public will therefore be included in the options to be discussed later in this document.

annual complaint report to both BOI and the State Health Commissioner. Section 38.2-4308( C) grants authority for the examination of complaint systems; its language was amended by HB 2785, so that BOI, in cooperation with The StateHMO complaint systems.[14] BOI also may now accept the State Health Commissioner's examination in lieu of making its own examination. Finally, Section 38.2-4316(A) establishes that BOI may suspend or revoke an HMO's license if certain conditions exist. One of these conditions is certification by the State Health Commissioner that the HMO is unable to fulfill its duties to provide quality health services (Section 38.2-4316(A)(4)).

> *Observation 8: VDH and BOI do not have a formalized public process whereby the State Health Commissioner "certifies" that an HMO is in good standing with regard to fulfilling its duties to provide quality health services.*

In addition to this oversight responsibility, the State Health Commissioner was granted expanded authority to oversee HMOs' health service quality with the enactment of HB 2785. Prior to HB 2785, Section 38.2-4315(B) prescribed that the State Health Commissioner *may* examine HMOs' quality of health care services. With the signing of HB 2785, the *Code of Virginia* was amended with the addition of *Article 7. Review of Health Services Quality, § 32.1-122.10:01* to Chapter 4, Title 32.1 (See text box above). Under this law, the State Health Commissioner *shall* examine the quality of health care services of HMOs, and the providers with whom they

[14]Prior to this change, the language was "The Commission or the State Health Commissioner may examine the complaint system."

conductbusiness. As a result, Section 38.2-4315(B) was amended to include only BOI's authority to conduct HMO examinations. In addition, both Section 32.1-122.10:01 and Section 38.2-4315(B) now contain subsections which prescribe that BOI and the State Health Commissioner will coordinate examinations "to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation."

> *Observation 9: HMO examination expenditures referred to in Section 32.1-122.10:01( C) include salary, travel, lodging, and meals. They do not allow for reasonable costs associated with non-personnel expenditures and complaint investigations, nor is the current mechanism adequate for funding the Center's newly added responsibilities.*

HMOs are required to maintain complaint data and must submit to both the Commissioner of Health and the Insurance Commissioner an annual complaint report which includes the total number of complaints and their underlying causes.

> *Observation 10: There is variability among Virginia HMOs in the form of the information contained in their complaint reports. For example, complaint classifications, the relative proportions of complaints by classification, and the level of detail provided varies among HMOs.*

**§ 32.1-122.10.01 Review of health maintenance organizations.**—A. The State Health Commissioner (the "Commissioner") shall examine the quality of health care services of any health maintenance organization ("HMO") licensed in Virginia pursuant to §§ 38.2-4301 and 38.2-4302 and the providers with whom the organization has contracts, agreements, or other arrangements according to the HMO's health care plan as often as considered necessary for the protection of the interests of the people of this Commonwealth. The Commissioner shall consult with HMOs and providers in carrying out his duties under this section.
B. For purposes of examinations, the Commissioner may review records, take affidavits, and interview the officers and agents of the HMO and the principals of the providers concerning their business.
C. The expenses of examinations by or for the Commissioner under this section shall be assessed against the organization being examined and remitted to the Commissioner.
D. In making his examination, the Commissioner may consider the report of an examination of a foreign HMO certified by the insurance supervisory official, a similar regulatory agency, an independent recognized accrediting organization, or the state health commissioner of another state.
E. The Commissioner also shall: (i) consult with HMOs in the establishment of their complaint systems as provided in § 38.2-4308; (ii) review and analyze HMOs' complaint reports which are required in subsection B of § 38.2-4308; and (iii) assist the State Corporation Commission in examining such complaint systems, as provided in subsection C of § 38.2-4308.
F. The Commissioner shall coordinate the activities undertaken pursuant to this section with the State Corporation Commission to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

VDH has authority to examine HMO grievance systems pursuant to licensure through the *Code of*

*Virginia* and through the Memorandum of Agreement with BOI. In addition, complaint reports are reviewed annually. However, there have been no administrative regulations promulgated to give VDH the authority to impose sanctions on HMOs and currently VDH can only make recommendations to BOI for sanctions.

> *Observation 11: Although VDH and BOI examine HMO complaint systems and annual complaint reports, neither has the authority to impose sanctions on an HMO on behalf of an individual in response to a specific complaint that has been investigated and found to have merit.*

***Individual protections:*** As discussed earlier, of the written complaints received by BOI in fiscal year 1996 relating to health insurance, there were fewer than 15 referrals of HMO complaints to the Center. The Center also received about 10 complaint calls directly from consumers last year. This may be attributable to several possible causes. Low complaint volume may be an indication that there is not great need. However, it is more likely that consumers with unresolved grievances are unaware that this resource exists. The most likely explanation is that, until 1997, VDH had no formal procedures in place to respond to complaints forwarded by BOI, and discouraged BOI from forwarding such complaints. Moreover, BOI's criteria for identifying quality of care complaints may have excluded some complaint types. These issues have since been addressed as part of the collaborative initiative between BOI and VDH. Now included in the complaint resolution procedures developed by the Center are detailed screening criteria for use by BOI in triaging incoming complaints. Major classifications are "access to health care services,"

**Complaints tracked by the Center for Quality Health Care Services and Consumer Protection (CQHCCP) between December 9, 1996 and July 21, 1997**

| | |
|---|---|
| Total Complaints received: | 31 |
| Complaints concerning access: | 6 |
| Complaints concerning utilization review: | 16 |
| Complaints concerning practitioners/providers: | 4 |
| Complaints that are non-jurisdictional: | 5 |

**Mechanisms through which complaints were submitted**

| | |
|---|---|
| Referral made by the Bureau of Insurance: | 23 |
| Referral made by the State Health Commissioner: | 2 |
| Referral made by the Medical Society of Virginia: | 2 |
| CQHCCP contacted by telephone: | 3 |
| CQHCCP contacted by mail: | 1 |

Of the 31 total complaints, 26 were submitted by the enrollee and 5 complaints were submitted by the enrollees' attending physician.

"utilization management," and "practitioner/provider issues." Detailed criteria are provided in Attachment I.

Section 32.1-122.10.01(E) requires the Health Commissioner to "review and analyze HMOs' complaint reports" pursuant to Section 38.2-4308(B) and to assist the Insurance Commissioner in the examination of complaint systems, pursuant to Section 38.2-4308(C). However, the authority for VDH to initiate an examination as a result of an individual complaint or pattern of complaints is not currently granted in statute.

*Observation 12: While authority for the examination of complaint systems is granted to VDH in Section 38.2-4308(C), the authority for examinations resulting from an individual enrollee complaint or pattern of complaints is not explicitly stated in Section 32.1-122.10.01.*

**Breakdown of Complaints concerning Utilization Review (*n*=16)**

| | |
|---|---|
| Denial of medically appropriate services: | 8 |
| Limitation on hospital length of stay: | 4 |
| Denial of specialist referrals: | 1 |
| Timeliness of preauthorized reviews: | 1 |
| Other: | 2 |
| Pre-existing condition | |
| Denial of selection of where to purchase contacts | |

**Closed complaints resolved as follows:**

| | |
|---|---|
| HMO resolved, treatment received to the satisfaction of the enrollee: | 3 |
| Physician withdrew the complaint; did not want to involve the patient: | 1 |
| HMO conducted appropriate investigation and followed company policy and procedures including contract: | 1 |
| Referred to another state as HMO was not licensed in Virginia: | 1 |

The Provider Focused Roundtable (May 6, 1997) and Consumer Focused Roundtable (May 23, 1997) conducted by the HB 2785 Study Group indicate that consumers and the providers who advocate for them are frequently uninformed or confused about the protections afforded them by the state. However, preliminary evidence from the formalized complaint resolution process and the collaborative initiative between VDH and BOI indicate that consumers are slowly becoming more aware of existing consumer protections, and are beginning to make their quality concerns known to VDH, either directly or through BOI. The Center has received 32 referrals from BOI in the two months since the referral process was formalized, and has consulted with BOI on additional calls which were not referred. Thus far, the Center reports that many of these calls are inquiries that involve providing information and educating consumers about their plans. These inquiries differ from complaints and grievances, in that corrective action is not yet warranted or

requested. Moreover, some inquiries, as well as complaints calls, may be outside the purview of the Center's current authority (e.g., calls relating to preferred provider organizations (PPOs).

> *Observation 13: Evidence from the Center's formal complaint process suggests that consumers are seeking information and education, in addition to complaint assistance. (The HB 2785 Consumer and Provider Focused Roundtables also corroborated that consumers and the providers who advocate for them are in need of information and education regarding the existing state protections available to them.)*

> *Observation 14: Consumers in PPOs and other forms of managed care are requesting information and assistance through the Center. However, the Center has no statutory authority to investigate quality of care complaints in PPOs, and other forms of managed care.*

***Collaborative Initiatives:*** Because of the low number of quality complaints received by the Center, it has begun to step up collaborative efforts with staff at BOI. The interim Memorandum of Agreement (MOA) between VDH and the SCC creates new opportunities for better data collection, complaint identification, and coordination between the agencies. Included in these coordinated functions are participation in BOI s market conduct examinations of HMOs, and in system level reviews of HMO complaints made by consumers and providers. The Center staff will also be able to respond to questions and provide assistance to other managed care consumers and to those with traditional indemnity insurance, should authority for this activity be granted, and resources become available. The MOA provides a flexible arrangement under which VDH and BOI can share respective expertise to research the types of quality assurance mechanisms that are necessary, so as to construct an oversight system that is the least intrusive for the industry.

This commitment to collaboration and coordination among state agencies has been further recognized through a recent National Academy for State Health Policy grant. This two-state demonstration grant was awarded to Virginia and Colorado to improve the quality of health care that low income women and children receive by improving collaboration and coordination among the state agencies responsible for oversight of Medicaid managed care. The three state agencies involved in Virginia—the Department of Medical Assistance Services, the Bureau of Insurance and the Department of Health—have established the project team and developed a work plan.

## Department of Health Professions: Oversight of Health Care Practitioners

The mission of the Department of Health Professions (DHP) is to assure safe and competent delivery of health care to citizens of the Commonwealth. Major activities include licensing, promulgating rules governing practice and taking disciplinary action. These responsibilities are accomplished through the operation of health regulatory boards. Ten of these twelve boards have statutory authority to issue licenses and certificates to providers whose clinical practices are often conducted in managed care settings. As of March 31, 1997, the number of practitioners currently credentialed was 220,347. Of these, 178,415 were resident in the Commonwealth. Licenses issued by these regulatory boards are required for legal, valid practice in the Commonwealth, and misdemeanor or felony prosecution can be sought for unlicensed practice[15] or practice subsequent to licensure suspension or revocation[16].

The following DHP boards have oversight authority for practitioners who may practice in managed care settings*:

Audiology and Speech Language Pathology
Dentistry
Medicine
Nursing
Nursing Home Administrators
Optometry
Pharmacy
Professional Counselors and Marriage and Family Therapists
Psychology
Social Work

* The Boards of Funeral Directors and Embalmers, and Veterinary Medicine are excluded from this discussion.

Jurisdiction of DHP extends to health care practice regardless of reimbursement or organization of a health care plan. For all practitioners, regulatory boards may impose a reprimand, fine, probation with specific terms or conditions of practice, or a suspension or revocation of a license, certification or registration. Parties to disciplinary proceedings include the Commonwealth and the practitioner. Action may be taken against an applicant or the holder of an expired license.

***Complaint and Report System:*** DHP receives information regarding alleged licensee violation of laws or regulations from a variety of sources, including health care consumers,

[15]Section 54.1-111

[16]Section 54.1-2409

coworkers, other licensees, government agencies, managed care entities, health care institutions, employers, insurance companies, and courts. The complaint intake unit of DHP's Enforcement Division receives the incoming complaint information, which may be conveyed in writing, through a call to the toll free complaint "hotline", or through a personal visit to the agency. The information is recorded and subsequently reviewed by an analyst to determine whether the alleged activity falls under the jurisdiction of the laws or regulations of a regulatory board; review is conducted irrespective of payment source or practice site in which the related health care service was rendered.[17] When initial review indicates that the complaint does not fall under the jurisdiction of a regulatory board, or represent a violation of a law or regulation of these boards, but may fall under the jurisdiction of another state agency, such as BOI or VDH, the information is forwarded to that state agency. When initial review demonstrates that this information is within DHP's jurisdiction and represents grounds for possible action, an investigation is initiated; the priority level and time standard for completion are established based upon the potential danger to public or patient health and safety. In all cases, DHP provides the information source with an explanation of the initial review results.

**Total Complaints from All Boards in 1996—3,233**

**Total Investigations Initiated for All Boards—1,658**
**(51% of all complaints)**

**Nature of All Complaints Investigated**

| | | |
|---|---|---|
| Unprofessional Conduct | 841 | 51% |
| Substandard Care | | 661 40% |
| 17 Other Categories | 156 | 9% |
| Total | 1,658 | 100% |

**Sources of All Complaints Investigated**

| | | |
|---|---|---|
| Required Reports | | 626 38% |
| Consumers | 427 | 26% |
| Other Sources | 518 | 31% |
| Anonymous | 87 | 5% |
| Total | 1,658 | 100% |

**Volume of Investigations by Board ***

| | | |
|---|---|---|
| Nursing | 607 | 40% |
| Medicine | 524 | 34% |
| Dentistry | 160 | 10% |
| Pharmacy | 116 | 8% |
| All others | 128 | 8% |
| Total | 1,535 | 100% |

* Includes only the 10 DHP boards under discussion. (47% of total complaints received; 93% of total investigations)

[17]Information alleging unlicensed practice of one of the health professions may result in a DHP investigation for the Commonwealth, even though none of the health regulatory boards has specific jurisdiction, with subsequent referral of the investigative report to a Commonwealth's attorney for prosecutorial consideration.

***Investigation of Report:*** Investigative staff of the four field regions and central administrative unit of the Enforcement Division receive specialized health care investigative training. Most investigators have either law enforcement or health care experience; some are current licensees of a health regulatory board. An investigation is conducted commensurate with case priority as well as case load of the assigned investigator, and includes interviews (i.e., information source, witnesses, accused licensee), and the collection of medical records and other evidence necessary to address the alleged violation(s). The department has broad investigative subpoena power. Investigation findings are provided to the appropriate regulatory board for consideration and action via a formal investigative report. The investigator also informs the information source of the ongoing status of the investigation, and notifies the source when the report has been forwarded to the appropriate board. If evidence indicates that a criminal law may have been violated, the investigator will work with law enforcement agencies; however, actions by the boards and the criminal justice system are taken separately.

***Board Review of Investigation, Case Decision:*** Upon Board receipt of an investigative report, a review is conducted to determine whether probable cause exists and charges should be made against a licensee. If the evidence is not sufficient, the case is closed, and the information source and licensee are notified. When probable cause is found, a notice of hearing or, in a limited number of cases, a pre-hearing consent agreement offer are issued to the licensee.[18] A public proceeding—an informal conference and/or a formal hearing—then follows, unless there is agreement for a consent offer. The information source is also notified. During this proceeding, the board, or a committee of the board, decides whether a violation of law or regulation has taken place, and if so, what disciplinary action or sanction will be imposed.

Currently, an exception to the process described above is permitted by some, but not all,

[18]Currently, some, but not all, Boards may make exceptions to these procedures if evidence indicates that practitioner conduct poses a "substantial danger to the public health or safety". The summary suspension that may be issued in these cases is discussed in the next paragraph.

boards when the evidence indicates that practitioner conduct represents a "substantial danger to the public health or safety." In these cases, a board may impose a summary suspension of that license. A formal hearing must be conducted after a summary suspension. Effective July 1,1997, all boards will have authority to issue summary suspensions. The law also provides for indefinite licensure suspension by the Director of DHP when the licensee has been convicted of a felony, has had his license revoked or suspended in another jurisdiction, or pays for a license with a dishonored check. A court, under certain circumstances, may suspend a license for non-payment of child support. Final board orders are almost always public documents, and they become part of the licensee's official, permanent licensing record. Of the investigations completed for, and considered by, these ten regulatory boards in 1996, 729 (47.5%) of these resulted in some type of disciplinary sanction, ranging from license/certificate revocation (approximately 8% of all disciplinary action) to a reprimand or warning (approximately 34%).

Examples of laws and regulations of the boards relating to professional practice standards are summarized below, according to several, more specific, categories.

*Licensing/Credentialing:* Statutory provisions require licensure[19] of 23 different types of health care practitioners under these ten regulatory boards, and regulation through certification of an additional 6 health care occupations,[20] and provide authority to establish competency standards, screen and issue licenses, receive and evaluate complaints against licensees, and issue disciplinary sanctions, including licensure revocation, against licensees. Boards are assisted in the detection of licensee practice problems through Section 54.1-2906, and Section 54.1-2907,[21] which both set out requirements under which health care institutions and providers must report specified circumstances. Section 54.1-2906 is reproduced on the following page..

[19]§ 54.1-102, 106, 111, 2409.1, 2603, 2709, 2710, 2711, 2714.1, 2715, 2722, 2723, 2725, 2726, 2902, 2929, 2942, 2956.8.9, 3008, 3102, 3204, 3310, 3506, 3606, 3706, *The Code of Virginia*, 1950, as amended.

[20]§54.1-2954, 2956, 3022, 3008, *The Code of Virginia*

[21]Section 54.1-2907 applies to providers treating other providers, and so is not reproduced in this document.

**§ 54.1-2906 of the *Code of Virginia***

***§ 54.1-2906. Hospitals and other health care institutions required to report disciplinary actions against and certain disorders of health professionals; immunity from liability.—*** *A. The chief administrative officer and the chief of staff of every hospital or other health care institution in the Commonwealth shall report to the appropriate board the following information regarding any person licensed by a health regulatory board unless exempted under subsection D:*

*1. Any information of which he may become aware in his official capacity indicating that such a health professional is in need of treatment or has been committed or admitted as a patient, either at his institution or at any other health care institution, for treatment of substance abuse or a psychiatric illness which may render the health professional a danger to himself, the public, or his patients.*

*2. Any information of which he may become aware in his official capacity indicating that such health professional may be guilty of unethical, fraudulent, or unprofessional conduct as defined by the pertinent licensing statutes and regulations.*

*3. Any disciplinary action, including but not limited to denial or termination of employment, denial or termination of privileges or restriction of privileges, while under investigation or during disciplinary proceedings, taken or begun by the institution as a result of conduct involving professional ethics, professional incompetence, moral turpitude, or substance abuse.*

*4. The voluntary resignation from the staff of the health care institution or voluntary restriction or expiration of privileges at the institution of any health professional while such health professional is under investigation or is the subject of disciplinary proceedings taken or begun by the institution or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct, moral turpitude, mental or physical impairment, or substance abuse.*

*Any report required by this section shall be in writing directed to the secretary of the appropriate board, shall give the name and address of the person who is the subject of the report and shall fully describe the circumstances surrounding the facts required to be reported. Any report required by this section concerning the commitment or admission of such health professional as a patient shall be made within five days of when the chief administrative officer learns of such commitment or admission.*

*The provisions of § 8.01-581.17 shall not bar (i) any initial report required by this section or (ii) any requested medical records which are necessary to investigate unprofessional conduct reported pursuant to this subtitle or unprofessional conduct that should have been reported pursuant to this subtitle.*

*B. The State Health Commissioner shall report to the appropriate board any information of which the Department of Health may become aware in the course of its duties indicating that such a health professional may be guilty of fraudulent, unethical, or unprofessional conduct as defined by the pertinent licensing statutes and regulations.*

*C. Any person making a report required by this section or testifying in a judicial or administrative proceeding as a result of such report shall be immune from any civil liability alleged to have resulted therefrom unless such person acted in bad faith or with malicious intent.*

*D. Medical records or information learned or maintained in connection with an alcohol or drug prevention function which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall be exempt from the reporting requirements of this section to the extent that such reporting is in violation of 21 U.S.C. § 1175 (a), 42 U.S.C. § 4582 (a), or regulations promulgated thereunder.*

*Observation 15: Section 54.1-2906(A) requires that hospitals and other health care institutions report to DHP any of the disciplinary actions or health conditions specified in Section 54.1-2906(A), items 1-4, regarding the practitioners with whom they contract. While HMOs and other managed care organizations contract with practitioners, they are not required by statute to report such problems to DHP.*

DHP is conducting a study regarding the applicability of licensing to UR agents who perform prospective utilization review. Currently, UR agents must obtain certification pursuant to *Title 38.2,*

Chapter 53, of the Code of Virginia.

**Professional Conduct***:* Standards for professional conduct expected of licensees of a board exist either in statute or board-established regulation. For example, Section 54.1-2914, under the Board of Medicine, outlines 16 activities considered unprofessional for practitioners of the healing arts regulated by this board, including.... "Conducts his practice in a manner contrary to the standards of ethics of his branch of the healing arts"[22]; ... "Conducts his practice in such a manner as to be a danger to the health and welfare of his patients or to the public"[23]; or, "Performs any act likely to deceive, defraud or harm the public"[24].

**Process to Appeal a Board Decision**: A licensee may appeal a board's decision in the disciplinary matter to a Circuit Court, which may uphold, suspend or set aside the decision or remand the matter back to the board for further proceedings. Appeals of action are relativity infrequent—less than ten per year. The licensee may appeal a Circuit Court's decision to the Court of Appeals, which has the same ruling options as the Circuit Court.

**Department of Medical Assistance Services: Oversight of Medicaid Programs**

As of June 1997, the Department of Medical Assistance Services (DMAS) has three managed care programs operational in the Commonwealth, serving about 300,000 beneficiaries. Medallion is a primary care case management program in which Medicaid clients are assigned to a primary care physician (PCP) who is paid a monthly case management fee in addition to fee-for-service. The PCP acts as a gate-keeper and must refer clients for most health services delivered outside of the PCP's office. Medallion includes most Aid to Families with Dependent Children (ADC) and Aged, Blind and Disabled (ABD) clients, and is operational state-wide except for the seven Tidewater cities in the Medallion II project.

[22]Section 54.1-2914(A)(9)

[23]Section 54.1-2914(A)(10)

[24]Section 54.1-2914(A)(13)

Medallion II, implemented January 1, 1996, is a mandatory HMO enrollment program for most ADC and ABD clients in Hampton, Newport News, Poquoson, Norfolk, Portsmouth, Virginia Beach and Chesapeake. In these cities, DMAS is contracted with four HMOs to provide all covered Medicaid services to eligible enrollees. As of June 1997, enrollment in Medallion II was approximately 86,000.

The *OPTIONS* program was implemented in January 1995 and offers ADC and ABD clients a choice of the Medallion program or a contracted HMO. *OPTIONS* is operational in the metropolitan areas of Northern Virginia and Richmond.

The quality oversight systems for Medicaid managed care populations have developed from the early 1990s and are driven by both state and federal influences. The Virginia General Assembly directed DMAS to develop a mandatory managed care program for Virginia in 1995. In order to establish the mandatory managed care program, DMAS then had to obtain a waiver from the federal Health Care Financing Administration. The terms of the waiver require certain quality oversight systems, including periodic independent assessments of the program's quality and cost effectiveness, as well as annual quality reports on the performance of each Medicaid HMO, as prepared by an Independent External Quality Review Organization. More recently, VDH began exercising its statutory prerogatives for licensed HMOs in April of 1996. Thus, oversight for the quality of care in HMOs for commercial and Medicaid populations have emerged somewhat independently in Virginia.

**Complaints:** In August 1996, DMAS contracted with an enrollment broker to serve three functions: client enrollment in HMOs and PCP selection assistance for the Medallion program; client education regarding managed care and HMO selection; and operation of a client help line. Benova, Inc., the contracted enrollment broker, receives and documents complaints received from Medicaid managed care clients.

All contracted HMOs are required to record and track complaints and to submit quarterly summaries of the complaints received from DMAS clients. Beginning in 1997, DMAS implemented

uniform complaint reporting with a requirement that all contracted HMOs use the same form for complaint summaries.

In addition to HMOs and the enrollment broker, internal agency staff may handle complaints from DMAS clients. DMAS has a special complaint form used for these complaints. DMAS then compiles all client complaints received via the above-referenced sources (enrollment broker, HMOs, and DMAS helpline). A system is under development whereby these complaints shall be tracked and analyzed by the Division of Policy and Budget. A system is also under development whereby complaints received by the DMAS helpline are being entered directly into a database that will allow for the identification of trends and similar analysis.

When complaints from clients concern specific episodes of care, DMAS may request that the External Quality Review Organization (EQRO) investigate the complaint in order to determine whether the client received appropriate care. The EQRO, as previously indicated, is under contract with DMAS to perform periodic medical audits/quality reviews, in fulfillment of HCFA requirements.

**Grievances and Appeals:** DMAS has established a formal appeals process for all Medicaid beneficiaries whereby any Medicaid client enrolled in an HMO may file an appeal directly to the HMO and/or to DMAS. The oversight and administration of this process is carried out by the 28 staff members that comprise the DMAS Division of Appeals. The Division is made up of a director, two managers, twelve hearing officers for recipient appeals (HMO appeals are all recipient appeals), two administrative hearing representatives for formal provider appeals, five informal appeal agents for provider appeals, one legal assistant, and five support staff.

Under the system that has been instituted, any Medicaid client enrolled in an HMO may file a formal (i.e., written) grievance in response to an action taken by an HMO that denies, terminates or reduces services. The grievance must be filed within 30 days of the action, unless there exists "good cause" to prevent a timely filing [25].

[25] 12VAC30-120-420 A & B

Any HMO receiving such a formal grievance is required to provide a copy of the grievance to DMAS within two business days[26]. Further, the HMO is required to issue a decision on the matter within 14 days[27]. A copy of the HMO's decision on the formal grievance is to be provided to DMAS and the client concurrently[28].

All of the formal grievance requests are logged by DMAS as appeal requests. If the HMO reaches a decision fully favorable to the client within the allotted 14 days, a DMAS hearing officer will administratively resolve the appeal. If DMAS has not been notified of the HMO's decision by the 16th day, or the HMO does not reach a fully favorable decision, DMAS will proceed with the process of contacting the appellant and scheduling a hearing. An informal hearing is then held and a decision is issued by the DMAS hearing officer. Note that this decision must be issued within 90 days of the date of the written grievance request, and that pursuant to the recent United States District Court case of Daniels v. Wadley, this period is determined from the time that the original grievance is made to the HMO. The decision of the DMAS hearing officer is binding and is the Commonwealth's final administrative action. The appellant has the authority, under Rule 2A:2 of the Virginia Supreme Court and the Recipient Appeals Regulations, to appeal the decision to Circuit Court.

As stated previously, DMAS, BOI, and VDH are currently studying ways to improve the quality of care for low income woman and children (and children with special needs) through efficient interagency collaboration. One area that has been studied is the overlapping responsibilities for oversight of the grievances filed by this population.

*Observation 16: The complaint classification schemes for quality of care concerns in Medallion II and in commercial oversight are dissimilar. However, a system is currently under development for classifying complaints with a classification scheme based upon the categories used by VDH.*

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[26]12VAC30-120-420 F

[27]12VAC30-120-420 H

[28]12VAC30-120-420 I

**U.S. Health Care Financing Administration: Oversight of Medicare Programs**

The U.S. Health Care Financing Administration (HCFA) requires that peer review organizations (PROs) perform mandatory case review of all beneficiary complaints concerning quality of care, regardless of the setting, and of all complaints alleging patient dumping, regardless of the source of the complaint. Additionally, the PRO reviews cases involving hospital- or managed care plan-issued notices of noncoverage where the beneficiary is 100% liable for the cost of care. Another independent entity—the Center for Dispute Resolution—reviews all other non-coverage and medical necessity determinations. Any referrals from HCFA, the Office of the Inspector General (OIG), intermediaries, carriers, or the managed care appeals contractor must also be reviewed by the PRO; the scope of the review is determined by the nature of the referral. If the PRO discovers, during the course of routine review or focused study, a problem indicating potential "gross and flagrant" violation of standards of care or unnecessary admission, the PRO must also investigate this.

There are 4,000 Medicare-eligible Virginians who receive care through Medicare HMOs (VAHMO, 1997). Virginia's PRO, the Virginia Health Quality Center (VHQC), administers the case review process for these beneficiaries, as well as all Virginians who have Medicare fee-for-service. VHQC reviews written complaints received from Medicare managed care enrollees, as well as calls received on VHQC s hotline. VHQC has the authority to issue an improvement action on the provider, and may impose sanctions through HCFA.

As discussed earlier in this document, VDH participates with BOI in the market conduct examination of HMOs, pursuant to the BOI/VDH interim Memorandum of Agreement. As part of this process, the VDH Center for Quality Health Care Services and Consumer Protection examines complaint records, including those of Medicare beneficiaries enrolled in the HMO under review. At the conclusion of each site survey, the Center's inspector also reviews the report of the latest HCFA-contracted inspection. If there are any material differences, these are noted by the Center's inspector, and are forwarded to HCFA.

**Department of Personnel and Training: Oversight of State Employee Health Benefits Program**

The State Employee Health Benefits Program, administered by the Department of Personnel and Training (DPT), offers two statewide managed care plans and a number of HMO plans which are each available in one or more regions of the state. The two statewide plans, Key Advantage and Cost Alliance, are self-insured, ERISA-exempt plans that are administered by Trigon Blue Cross Blue Shield. DPT is responsible for plan oversight, and, as such, neither BOI nor VDH have any oversight authority relating to these plans.[29] The HMO plans offered through the program are fully insured. Thus, BOI and VDH, as well as DPT, have oversight responsibility.

All employees and family members covered in the State Group have available to them an appeals procedure through their plan. There is a description of each plan's appeals process in the plan member handbook, which is distributed to each enrolled employee. If an individual considers a dispute unresolved after the plan's appeals process has been exhausted, the member may exercise his or her right to an executive appeal to the Director of DPT. Upon receipt of an executive appeal, there is an analysis to assure that the complainant has received due process through the plan's appeals procedures. The DPT review is not a de novo determination; however, DPT does explore quality issues to secure resolution through formal or informal means. Executive appeals must be received in writing and the response returned in writing.

> *Observation 17: The State Employee Health Benefits program handles complaints for state employees enrolled in HMOs. However, their valuable data on complaints would be lost if SEHBP did not work collaboratively with the BOI, VDH, DHP, and DMAS to adopt screening criteria, record and track the complaint according to the screening criteria in this report.*

**Office of the Attorney General: Consumer Representation (No Direct Oversight Role)**

As previously mentioned, the Office of the Attorney General does not have a direct role in grievance system oversight. However, the Division of Consumer Counsel within the Office of the Attorney General is charged with representing consumers before governmental departments, commissions and agencies. Section 2.1-133.1 of the Code of Virginia provides the authority for the establishment of the Division of Consumer Counsel. Cases handled by the Division are those affecting many consumers. The Division does not investigate individual health insurance

[29]BOI regulates insurance carriers, but not insurance activity that is incidental to the primary purpose of an organization. The Commonwealth is not in the business of insurance.

complaints, but does refer such complaints to BOI's Life and Health Consumer Services Section (JCHC, 1996). ***IV.*** **SUMMARY OF OBSERVATIONS**

**Observation 1 (p. 9)**

The DOL may not provide, in general, the level of individual protections offered by states. However, it appears to offer some individual protections that the Virginia Department of Health (VDH) does not provide with regard to quality complaints. VDH does not currently provide individual assistance in the form of advising enrollees, members and subscribers of their rights, nor information regarding how state law may apply to a complainant's situation, as the DOL provides with regard to federal law.

**Observation 2 (p. 11)**

In Virginia, consumer complaint calls are most often received by BOI; those relating to ERISA plans are referred to the DOL. ERISA complaint volume is not currently being tracked by BOI.

**Observation 3 (p. 12)**

The Code of Virginia does not adequately define key concepts necessary to the oversight of complaint systems, such as 'inquiry', 'complaint', and 'grievance'. Of the three, only 'complaint' is defined in the Code.

**Observation 4 (p. 13)**

VDH has authority for quality oversight of HMOs, but not for other forms of managed care. Subscribers and enrollees who call the BOI with quality complaints against managed care plans other than HMOs do not have their complaints addressed under the current system.

**Observation 5 (p. 24)**

A commercial HMO enrollee wishing to grieve a utilization review decision has significantly different options depending on whether he uses the HMO grievance system or the provisions of Chapter 54. The latter approach provides for a more rapid response, but appears to require the advocacy of his treating provider for the first stage of the process, the request for reconsideration. Chapter 54 also permits the enrollee a representative. The requirements for HMO grievance systems do not recognize a representative or provider advocate. Chapter 54 requires a peer of the treating physician to review reconsideration and appeal requests, but no such requirements are in evidence

for HMO grievance systems.

**Observation 6 (p. 24)**

Utilization review standards and appeal legislation was passed in 1995, and requirements have now been in place for two years. Entities subject to Chapter 54 should now have two years' worth of information on UR review complaints received, their resolution, numbers and types of adverse decisions and reconsideration, numbers and outcomes of final adverse decisions and appeals, and separate records for expedited appeals.

**Observation 7 (p. 24)**

Nearly 1,000 UR entities subject to Chapter 54 must collect and make UR records available for review by BOI, but there is no requirement to submit records of utilization review complaints and appeals to BOI, if requested, or to VDH. No analysis has been conducted on these data. Moreover, medical necessity determinations under utilization review may be outside the scope of BOI's insurance regulatory functions.

**Observation 8 (p. 26)**

VDH and BOI do not have a formalized public process whereby the Health Commissioner "certifies" that an HMO is in good standing with regard to fulfilling its duties to provide quality health services.

**Observation 9 (p.27)**

HMO examination expenditures referred to in Section 32.1-122.10.01( C) include salary, travel, lodging, and meals. They do not allow for reasonable costs associated with non-personnel expenditures and complaint investigations, nor is the current mechanism adequate for funding the Center's newly added responsibilities. The current mechanism is inadequate to provide sufficient resources to implement new responsibilities.

**Observation 10 (p.27)**

There is variability among Virginia HMOs in the form of the information contained in their complaint reports. For example, complaint classifications, the relative proportions of complaints by classification, and the level of detail provided varies among HMOs.

**Observation 11 (p.28)**

Although VDH and BOI examine the complaint systems and the annual complaint report, neither has the authority to impose sanctions on an HMO on behalf of an individual in response to a specific

complaint that has been investigated and found to have merit.

**Observation 12 (p. 29)**

While authority for the examination of complaint systems is granted to VDH in Section 38.2-4308(C), the authority for examinations resulting from an individual enrollee complaint or pattern of complaints is not explicitly stated in Section 32.1-122.10.01.

**Observation 13 (p. 29)**

Evidence from the Center's formal complaint process indicates that consumers are seeking information and education, in addition to complaint assistance. The HB 2785 Consumer and Provider Focused Roundtables also indicate that consumers and the providers who advocate for them are in need of information and education regarding the existing state protections available to them.

**Observation 14 (p. 30)**

Consumers in PPO's and other forms of managed care are requesting information and assistance through the Center. However, the Center has no statutory authority to investigate quality complaints in PPOs, and other forms of managed care.

**Observation 15 (p. 35)**

Section 54.1-2906(A) requires that hospitals and other health care institutions report to DHP any of the disciplinary actions or health conditions specified in Section 54.1-2906(A), items 1-4, regarding the practitioners with whom they contract. While HMOs and other managed care organizations contract with practitioners, they are not required by statute to report such problems to DHP.

**Observation 16 (p. 39)**

The complaint classification schemes for quality of care concerns in Medallion II and in commercial oversight are dissimilar.

**Observation 17 (p. 41)**

The State Employee Health Benefits program handles complaints for state employees enrolled in HMOs. However, their valuable data on complaints would be lost if SEHBP did not work collaboratively with the BOI, VDH, DHP, and DMAS to adopt screening criteria, and to record and track the complaint according to the screening criteria in this report.

## V. OPTIONS FOR THE STATE HEALTH COMMISSIONER TO CONSIDER

### 1. State Action Benefits Only a Relatively Small Percentage of Insured Virginians.

The Joint Commission on Health Care (JCHC) has reported that many of the Commonwealth s health insurance laws and regulations affect only about 25% of Virginians, approximately 19% in commercial group insurance and 6% with individual coverage (JCHC, 1996). This is due to the preemption of state law for self-funded plans through ERISA, and to the major role of the federal government in oversight of publicly funded programs. The JCHC estimates that, in 1992, 35% of Virginians were in ERISA plans. Comparable proportions for publicly funded plans were Medicare (12%), Medicaid (6%), and CHAMPUS (7%). At that time, it was estimated that 15% of the Virginia population was uninsured.

As discussed earlier in this paper, authority to regulate enrollee complaint systems and quality of care, as granted in Title 38.2, Chapter 43 of the *Code of Virginia*, applies to HMOs only. The Virginia Association of Health Maintenance Organizations (VAHMO) reports that enrollment in HMOs stood at nearly 1.38 million enrollees as of December 1996 (VAHMO, 1997), and included approximately 129,000 Medicaid recipients enrolled in Options and Medallion II. Thus, the commercially insured HMO population represents a substantial proportion of the 25% of Virginians protected by existing state health insurance laws and regulations.[30]

Standards for UR and appeals of final adverse UR decisions, as established in Title 38.2, Chapter 54, apply not only to HMOs, but to all managed care entities performing UR internally. It is probable that these laws and regulations affect a substantial proportion of the 25%, since traditional indemnity insurance is becoming less and less common, and all managed care entities, by definition, perform UR to some extent.

The *need* for an ombudsman or external appeal process may also be dependent upon the payer. For state employees, the DPT provides assistance and advocacy, and offers an administrative

[30]Some employer-based plans are moving into risk-sharing when contracting with HMOs, and as a result, are ERISA self-insured plans. A 1996 KPMG survey of employers with 200 or more employees reported that 20% of members were enrolled in fully or partly self-insured HMO plans (KPMG, 1997). This was up from 13% in 1995. In 1989, a Foster-Higgins survey found that only 4% of HMO plans were self-funded.

appeals process as well. Large employers, by virtue of their purchasing power, might be able to use persuasion very effectively in advocating for an enrollee, the implication being that there would be less of a need for an ombudsman or external appeals process. However, it may not be in the employer's best interest to support employees' benefit claims, especially if the employer is self-insured or experience-rated, which most large employers are. Commercially insured enrollees employed by smaller companies may fare no better. That is, not only could small employers' interests deter employee advocacy, but their lack of negotiating strength could limit the assistance they could offer. On the other hand, small employers who participate in purchasing cooperatives might have more negotiating strength, thus mitigating this situation somewhat. Finally, persons insured individually would not have an employer as a potential source of assistance with grievances.

ERISA self-insured employers may offer education and assistance services to their beneficiaries, and are required to uphold certain fiduciary responsibilities in their reviews of beneficiary grievances. Yet, as already discussed, DOL does not provide the level of individual complaint investigation typically provided by state insurance regulators. States, including Virginia, have become increasingly concerned that the limited grievance protections under ERISA will only become more problematic as more employers self-insure.[31] These concerns are evidenced in a National Governors' Association (NGA) report which calls upon the federal government to address these inequities. Two options are proposed by the NGA to address these inequities:

> Congress should work with the states to establish national health care standards for self-funded plans that are similar to those imposed by states on commercial plans. If Congress is unwilling to define legislative standards in ERISA, the U.S. Department of Labor, in conjunction with the states, should be given the authority to develop regulations that, at the very least, establish essential consumer protections and remedies standards for self-funded plans.
>
> Anecdotal evidence suggests that consumer protections problems are more likely to arise in small self-funded plans. Congress could limit self-funding authority to businesses above a certain size. Businesses below that limit would be required to follow state laws. The U.S. Department of Labor would need to enforce standards for those plans that remain under its jurisdiction. (NGA, 1997)

Should such options be implemented, they would affect the number of Virginia residents eligible for state-initiated protections.

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[31]States are also concerned about the growing number of smaller employers who self-insure and purchase stop-loss coverage. By purchasing stop-loss coverage, sometimes at a very low threshold, these employers bear only a portion of the risk, and are able to avoid state regulation with regard to health insurance. Court cases on states' ability to regulate them have been mixed.

As discussed previously, Virginia s Medicaid population enrolled in Options, Medallion I and Medallion II managed care programs are afforded processes for dispute resolution through DMAS. Likewise, Medicare beneficiaries are afforded similar protections by the U.S. Health Care Financing Administration. In addition, the protections available to the commercially insured population through BOI, VDH and DHP are also available to Medicare and Medicaid beneficiaries.

**2. The Main Point of Entry into the State System is BOI. However, There Are Other Access Points, Which May Create Confusion for the Consumer (Observation 2).**

The main entry point for consumers with inquiries and/or complaints relating to their managed care plans is through BOI's toll-free phone number. Yet, consumers may also enter the state system through other agencies, and may find the system difficult to navigate if coordination among agencies is lacking. Moreover, if an agency's complaint protocols are dissimilar from others, and/or do not include coordination with other agencies, a consumer might obtain different results, depending on the agency consulted and the enforcement authority available to it. For example, a consumer in an ERISA plan who contacts BOI will be referred to the DOL, but would not necessarily be referred to the DOL if initial access was through another agency. To address this issue, collaboration between BOI and other state agencies could be explored to insure that ERISA complaints received by other agencies are identified and forwarded to BOI.

The Center's formalized process for coordinating complaints with BOI has been completed, and is provided in Attachment II as an example of complaint coordination.

**3. Members and Subscribers in Other Managed Care Plans Do Not Enjoy the Same Level of Consumer Protections as Those Enrolled in HMOs (Observations 2 and 4).**

PPOs and other non-HMO managed care plans are regulated as insurance plans. The protections of Chapter 54 apply to these entities, and to all forms of health insurance, if they perform UR internally. However, unlike HMOs, PPOs and other non-HMO managed care plans have no statutory or regulatory requirements for a grievance system, nor does VDH have any authority to investigate the quality of care complaints of subscribers and enrollees in these plans.

For managed care organizations that have incentives to use networks, more oversight than is currently provided by statute and regulation may be needed. In order to do this, "managed care plans other than HMOs" must first be defined. BOI is currently studying additional regulation of managed care health insurance plans (SJR 611) and whether the quality and consumer protections contained in Chapter 43 of the *Code* should apply to those entities. Therefore, HB 2785 judgements about regulating other managed plans need to be coordinated with the study findings of SJR 611.

Virginians in ERISA plans also do not enjoy the same level of protections as those enrolled in HMOs. For these consumers, BOI could consider recording the number and nature of incoming complaint calls relating to ERISA plans, with the intent of pursuing an agreement similar to the Oklahoma/DOL partnership on ERISA complaint investigation. While the DOL does not currently have plans to include other states in pilot programs, this policy could change, especially if the Oklahoma demonstration is successful. Data on ERISA complaint calls received by BOI would provide supporting documentation, should there be future interest in Virginia cooperating with DOL on a similar project. In the meantime, BOI could consider communicating with the Assistant Secretary of the Pension Welfare Benefits Administration to express Virginia's interest in participating in future opportunities.

**The Pennsylvania Department of Health publishes HMO grievance system operational standards which include the following definitions:**

**Inquiry:** An inquiry is any member's request for administrative service, or information, or to express an opinion. Whenever specific corrective action is requested by the member, or determined to be necessary by the HMO, it should be classified as a complaint.

**Complaint:** A complaint is an issue a member presents to the HMO, either in written or oral form, which is subject to informal resolution by the HMO within a thirty-day period. All HMOs must establish and maintain an effective complaint resolution system, including a written log of each complaint and its disposition. Failure to render a decision within the thirty-day time frame automatically results in the complaint being upgraded to a grievance.

**Grievance:** A grievance is a complaint which cannot be resolved to the member's satisfaction or when the member requires formal grievance consideration during the thirty-day period. All grievances shall be committed to written form either by the member or the HMO prior to processing.

Source: Pennsylvania Department of Health, *HMO Grievance Systems: Operational Standards for Fundamental Fairness for HMO Members*, August, 1991.

**4. Consumers Would Benefit from a More Uniform Complaint/Grievance System Based on a Common Set of Key Concepts (Observations 3, 10, 16, 17, and 18).**

The state oversight system for

complaints and grievances is complex. despite the potential benefits of VDH's involvement in quality of care oversight for consumers, VDH's entry into the existing oversight structure will not completely eliminate confusion among consumers seeking complaint remedies. However, there are steps that the state can initiate at the system level to reduce confusion and to benefit consumers in general. First, all state agencies involved in consumer oversight of complaints relating to the care delivered in managed care organizations, including HMOs, could adopt a common set of terms central to the complaint/grievance systems. For example, both the commercial and Medicaid complaint/grievance systems could use the same terms and definitions of the key concepts. This report suggests that 'inquiry,' 'complaint,' and 'grievance,' be defined in statute so that regulatory agencies can write them into their formal guidance including regulations and contracts. The adoption of 'inquiry' recognizes the principle that MCOs should be given opportunity to resolve disputes about their own plans and to assist their members in seeking mutually satisfactory solutions before requesting government intervention. 'Complaint,' and 'grievance' are defined by the level of formality, point in the process, and cause for remedy. Definitions similar to those used by Pennsylvania, which are shown in the nearby text box, could be codified.

A second step that the state could take involves a uniform classification of quality of care complaints. The state agencies responsible for oversight of managed care plans could adopt a single scheme to screen quality of care complaints. BOI, VDH, and DMAS, as well as DPT, could continue to collaboratively develop more uniform classifications of complaints, both to simplify the system for consumers and to permit comparison and analysis across plans.

The screening criteria developed by the Center (Attachment I) provide an example of complaint classification. The three main classifications are "access to health care services," "utilization management," and "provider/practitioner concerns and issues." Several agencies have indicated that greater coordination and collaboration in this area would benefit consumers. The combination of the common terms and classifications across state agencies will help consumers and policy makers to observe the types of problems that Virginians are having with their health plans.

The public would also benefit from a tracking report, which could be generated from the annual complaint report submitted by all HMOs. Complaints and grievances could be followed and become part of a public record that the State Health Commissioner submits to the Commissioner of Insurance annually. A tracking report, and therefore, HMOs' annual complaint reports, would require 'key concept' definitions and standardized complaint classifications to be informative. A requirement for HMOs to use standardized complaint classifications in their annual reports would not require legislation, since Section 38.2-4308(B) states that HMOs must submit an annual complaint report "in a form prescribed by the (State Corporation) Commission, after consultation with the State Health Commissioner."

5. The VDH Could Assume New and Increased Responsibility for Educating Consumers and Facilitating the Resolution of Their Complaints (Observations 1, 13, and 14). In the past, the previously named Office of Health Facilities Regulation (OHFR) provided education and training opportunities for facility staff. However, during the transitional period since OHFR was renamed as the Center for Quality Health Care Services and Consumer Protection, it has been trying to adapt its mission to include education for consumers enrolled in HMOs. The Center's complaint resolution experience to date demonstrates that consumers are seeking education and information about their plan rights and responsibilities, in addition to other complaint assistance. The shift toward consumer education is viewed as a modified ombudsman role. The Center is finding that these consumers are enrolled in all types of managed care plans, not just in the plans (HMOs) for which the Center currently has oversight authority.

Public policy related to this new role should not supplant the customer service and grievance functions that are available to consumers through their plans, and that are the responsibility of the managed care plans. Nor does the Center wish to take over functions, such as submitting the complaint to the HMO's internal grievance system, which should remain the responsibility of the "fair-minded consumer." Instead, the Center could be part of a larger effort, in conjunction with other state agencies and private entities, to provide education and information to consumers regarding their health plans. In this role, the Center would be available to advise an enrollee of his rights, to provide information about how state law may apply to the enrollee's situation, and to

encourage the enrollee to reconnect with the plan's internal grievance system. In addition, the state would ensure that it has additional resources to handle inquiries and complaints not just from HMO enrollees, but for consumers of other forms of managed care as well.

As discussed earlier in this document, the functions of the Educator/Facilitator could be explicitly considered in determining the staffing needs for quality oversight. A determination of the full-time equivalents needed for these responsibilities could be made, and a budgetary amendment developed for funding them. If VDH oversight expands to other forms of managed care, the new responsibility should not be funded solely by HMOs through their examination fees. Instead, there could be a mechanism, such as a certification process, through which other forms of managed care entities would support these functions.

**6. Grievance Protections for Utilization Review Denials Could be Coordinated with Chapter 43, and Could Include the Covered Person in all Levels of Appeal (Observations 5, 6, and 7).**

Both the grievance system prescribed by statutes (Chapter 43) and regulations, and the appeal process prescribed by Chapter 54, could be coordinated to more adequately protect consumers who wish to grieve utilization review decisions. Complaint system regulations do not provide for a timely response from the HMO or for review by a peer of the treating provider. The language of Chapter 54 is confusing on certain points. It does not appear to permit a consumer to initiate a request for reconsideration (Section 38.2-5406(A)), or to require that HMOs share UR criteria with consumers, only with providers (Section 38.2-5402(A)). In order to address these issues, consideration could be given to amending statutes and regulations addressing HMO grievance systems in order that they contain the identical requirements for UR grievances as are found in Chapter 54, such as the response time from HMOs in responding to grievances concerning UR decisions. In addition, consideration could be given to amending Chapter 54 to clarify that it includes "covered person," so that it is explicit that an HMO member can initiate a reconsideration of an adverse decision, and have access to the UR criteria pertinent to his case, without the intervention of the treating provider. Finally, an amendment to Chapter 54 could also specify that UR appeal rights be included alongside the grievance system description in the evidence of coverage issued by the HMO.

Utilization review appeals, so central to the quality "feedback loop," can be made more effective tools for finding mutually satisfactory solutions in disputes between the enrollee and the UR entity. The collection and compilation of a sample of UR data would provide important information regarding the implementation of Chapter 54. Annual submission and review of utilization review records would provide important system-level consumer information. Since the Bureau of Insurance has no authority to adjudicate controversies arising out of Chapter 54, nor does it report having the clinical expertise to evaluate the appropriateness of UR denials, it is appropriate for VDH to assume statutory responsibility for oversight and administration of Chapter 54, and for the Health Commissioner to establish a method for evaluating compliance with Chapter 54. With regard to Chapter 53, DHP's interest is very narrow. Therefore, it may not be appropriate to transfer oversight and administration of Chapter 53 to DHP.

**7. The Enforcement of Sanctions Resulting from Violations of Law Will Continue to Be the Focus of State Oversight. However, VDH Would Need New Authority to Discharge its Statutory Mandate (Observations 8, 9, 11, 12,).**

It is important to emphasize that the HMO statutes and regulations provide for HMO grievance and quality *systems*. Enforcement by regulatory agencies ensures that the systems are in place for appropriate grievance and quality protections.

BOI has broad authority to enforce provisions of Title 38.2 of the *Code of Virginia* under which all insurance statutes are included. The primary source of BOI's enforcement authority is found in Section 38.2-218 through Section 38.2-221. Among other penalties, the Bureau, through the State Corporation Commission, is authorized to:

> impose a penalty of up to $5,000 for each knowing or willful violation of any provision of Title 38.2 or any regulation issued by the SCC pursuant to Title 38.2;
>
> impose a penalty of up to $1,000 for each violation of Title 38.2 or any regulation issued by the SCC pursuant to Title 38.2 committed without knowledge or intent. For a series of related violations resulting from the same act, the penalty is capped at $10,000;
>
> require the payment of restitution under certain named circumstances;

issue cease and desist orders, temporary injunctions and permanent injunctions, and may impose monetary penalties of up to $1,000 per day for violations of such cease and desist orders and injunctions (Sec. 12.1-33). In addition, the SCC has the authority to enforce its injunctions by civil penalty or imprisonment;

suspend or revoke the authority of an insurer or HMO to transact business in the Commonwealth.

The role of the State Health Commissioner lacks actual enforcement authority; rather, " an HMO license may be suspended or revoked by BOI upon the State Health Commissioner's certification to the [State Corporation] Commission that an HMO cannot furnish quality health services consistent with prevailing medical standards and practices." (Section 38.2-4316(A)(4)) This certification authority is limited only to the State Health Commissioner's verified reports to the State Corporation Commission with respect to the systemic inability of an HMO generally to furnish services that fail to meet professional standards for quality of care. Such certification does not apply directly to the HMO licensee. The governing statute does not address individual consumer grievances and appeals for purposes of the State Health Commissioner's review. Further, there is no current authority for the State Health Commissioner to certify that an HMO *can* furnish quality health services. Even under the new mandate effective July 1, 1997, there is no authorized process for certification of HMOs for recognized quality of care. Thus, consideration could be given to enabling legislation that would authorize the State Health Commissioner to establish a certification process (as contrasted with the licensing process performed by BOI) under which HMOs would submit to quality of care review culminating in a certification from VDH. This certification process could be renewable and reviewable at some established interval, affording VDH the opportunity to review the HMO's quality of care on a regular basis. The sanction for an HMO's failure to adhere to VDH's standards for quality of care, then, could be loss of certification, and, if the General Assembly so determined, monetary penalties, with the licensee's right of appeal to BOI from recommendations to BOI. Only in the event that the State Health Commissioner became convinced that a particular HMO's general services were systematically and sufficiently egregious to justify license termination would the State Health Commissioner certify such a recommendation to BOI.

HB 2785 requires the State Health Commissioner to "examine the quality of health care services of any health maintenance organization" as well as to examine the complaint system of HMOs. The new statute does not, however, provide authority for the State Health Commissioner or the Board of Health to set standards to be met by HMOs with regard to the quality of health care provided by HMOs, or the standards which should be met by the enrollee grievance system with regard to quality of care. Additionally, the State Health Commissioner is not granted the authority under current statutes to enforce sanctions for non-compliance with quality of care standards, short of reporting to the State Corporation Commission that an HMO is unable to furnish quality health care and should have its license revoked as provided in Section 38.2-4316(A)(4) of the *Code of Virginia*. In short, the State Health Commissioner lacks enforcement authority. A regulatory scheme permitting the State Health Commissioner to impose more reasonable sanctions for violations of activities regulated by VDH might be more appropriate.

The State Health Commissioner could consider proposing legislation that would authorize the Board of Health or the Commissioner to issue certificates of HMO compliance with grievance and quality standards. Further, such legislation would authorize the Board of Health to develop and promulgate regulations to establish procedures of review, standards for review of grievance systems, and mechanisms for enforcement based upon severity and scope of noncompliance. Such new legislation would relieve BOI of its responsibility to enforce findings of a sister agency by sanctions of its licensees. The Commissioner would continue to report certification activities to the BOI as licensing agency.

**8. Enforcement for Individual Complaints Involving Quality of Care Is Problematic.**

Review of specific individual quality of care complaints has not been legislatively established. Section 38.2-4316.A(4) of the *Code of Virginia* defines quality health services as those that are "consistent with prevailing medical standards and practices." Under section 38.2-4308 of the *Code* and the interim Memorandum of Agreement executed in late 1996, BOI refers quality of care complaints to the State Health Commissioner, but such complaints are limited to those that implicate an HMO's complaint system. The authority for the State Health Commissioner to conduct examinations in response to individual complaints is not conferred under section 32.1-122.10.01 of

the *Code*, which assures only that the State Health Commissioner shall examine the quality of health care services of any licensed HMO "as often as considered necessary for the protection of the people of this Commonwealth." Arguably, under this authority, and that of the interim Memorandum of Agreement, the State Health Commissioner may investigate individual cases and find that a particular consumer's complaint appears to have merit. The State Health Commissioner may provide that analysis with expert discretionary findings; however, the State Health Commissioner has no sanction authority. The State Health Commissioner can only advise BOI of its findings. The SCC's sanction authority is limited to violations of Title 38.2 and regulations issued pursuant to Title 38.2. An individual instance in which the State Health Commissioner reports that the HMO apparently failed to provide quality health care to an individual complainant is not sufficient under the insurance laws for the SCC to initiate an action.

Individual complaints on quality concerns, even when possibly meritorious on analytical review and reported by the State Health Commissioner, are not sanctionable by the State Health Commissioner, BOI or any other regulatory agency. Thus, an important function of this analysis is to identify and engage such reviews and reports into some process that does not implicate such analytical reviews and reports in any future individual process. As stated in section 38.2-4319( C) of the *Code*, an HMO "...shall not be deemed to be engaged in the unlawful practice of medicine"; thus, while an individual complaint investigation, on review, may report that the HMO has not provided care in accordance with prevailing standards and practices, at the present time sanction authority is absent unless the practice is systemic and leads to State Health Commissioner certification to suggest BOI imposition of suspension or revocation of licensure.

It is important to emphasize that providing remedies to individuals who appear to have meritorious grievances is not the role of regulatory agencies. Individual complaints reside in the courts. This is not to say that BOI and VDH may not assist in the relief when an individual's grievance has been investigated and, on analysis, appears founded. BOI's staff will make numerous efforts to convince the insurer or HMO to modify or retreat from its position, and, in many cases, such efforts are successful. Further, when a practice discovered during the handling of a complaint can be determined to be a violation of the insurance laws or regulations, BOI can and does initiate

disciplinary proceedings against the insurer or HMO. Such proceedings may result in a settlement, one component of which may be to provide the resolution sought by the individual complainant. In fact, such settlements may result in relief for other similarly situated individuals who may not have filed a complaint. However, BOI's role is not one of adjudicating individual complaints, nor does BOI (or VDH) have the authority to do so.

Similarly, upon investigation and analysis of an individual's complaint about a hospital or nursing facility, VDH may find that the complaint appears founded. The individual will receive a copy of VDH's report on the investigation, but VDH has no authority to require the facility to provide a remedy to compensate the individual for the wrongful act or omission. The individual must pursue a remedy or damages in civil court.

It must be stressed again that BOI has no authority to adjudicate controversies arising out of Chapter 54 of Title 38.2, which governs utilization review appeals. There is general agreement that the majority of utilization review appeals arise from disputes of a medical nature. BOI does not have jurisdiction to adjudicate contract disputes. In this regard, 14 VAC 210-140 states, "The Commission shall have no jurisdiction to adjudicate controversies between a health maintenance organization and its enrollees, and a breach of contract shall not be deemed a violation of this chapter."

Thus, while BOI and VDH may investigate complaints, and BOI can enforce the provisions of Title 38.2 and the regulations issued pursuant to Title 38.2, these regulatory agencies do not have the authority to require that an HMO provide relief to the individual with an apparently valid grievance concerning quality of care. Individuals would seek such relief in court. However, under Virginia law, a claimant cannot seek punitive damages (Section 38.2-4319(C)).

### 9. Consumers Would Benefit From Improved Reporting of Disciplinary Actions Against Network Physicians (Observation 15).

Consideration could be given to including HMOs and other managed care organizations in the statutory language of Section 54.1-2906, which currently sets forth the requirements for hospitals

and other institutions to report certain disciplinary actions and medical conditions to DHP.

## ATTACHMENT I

## SCREENING CRITERIA FOR COMPLAINTS THAT MAY ADDRESS QUALITY OF CARE ISSUES
### Virginia Department of Health
### Center for Quality Health Care Services and Consumer Protection

The VDH will investigate complaints where the quality of the health care services provided to enrollees by a health maintenance organization (HMO) licensed in Virginia, or one of its contractors, is in question. The quality of health care services provided by an HMO will be reviewed within the context of the enrollee's health plan coverage, mandated benefits, and the laws and regulations governing the provision of health care services provided by the health maintenance organizations and their providers contained within the *Code of Virginia*, 1950, as amended, and the *Virginia Administrative Code*.

Complaints concerning the quality of health care services can generally be applied to the categories that are listed below.

ACCESS TO HEALTH CARE SERVICES

Geographic access limitations to providers and practitioners
Availability of PCPs, specialists, behavioral and mental health providers
PCP after-hour access
Access to urgent care and emergency care
Out-of-network access
Availability and timeliness of provider appointments and provision of services
Availability of outpatient services within the network (to include HHA, hospice, labs, physical therapy, radiation therapy)
Enrollee provisions to allow transfers to other PCPs
Patient abandonment by PCP
Pharmaceuticals (based on patient's condition, use of generic drugs versus brand name drugs)
Access to preventative care (immunizations, prenatal, STDs, alcohol, cancer, coronary, smoking)
Access to HMO complaint and grievance procedures
HMO enrollee notification regarding changes in the EVIDENCE OF COVERAGE and mandated benefits

UTILIZATION MANAGEMENT

Denial of medically appropriate services covered within the enrollee contract
Limitations on hospital length of stays for stays covered within the enrollee contract
Timeliness of preauthorization reviews based on urgency
Inappropriate setting for care i.e. procedure done in an outpatient setting that should be performed in an inpatient setting
Criteria for experimental care
Unnecessary tests or lack of appropriate diagnostic tests

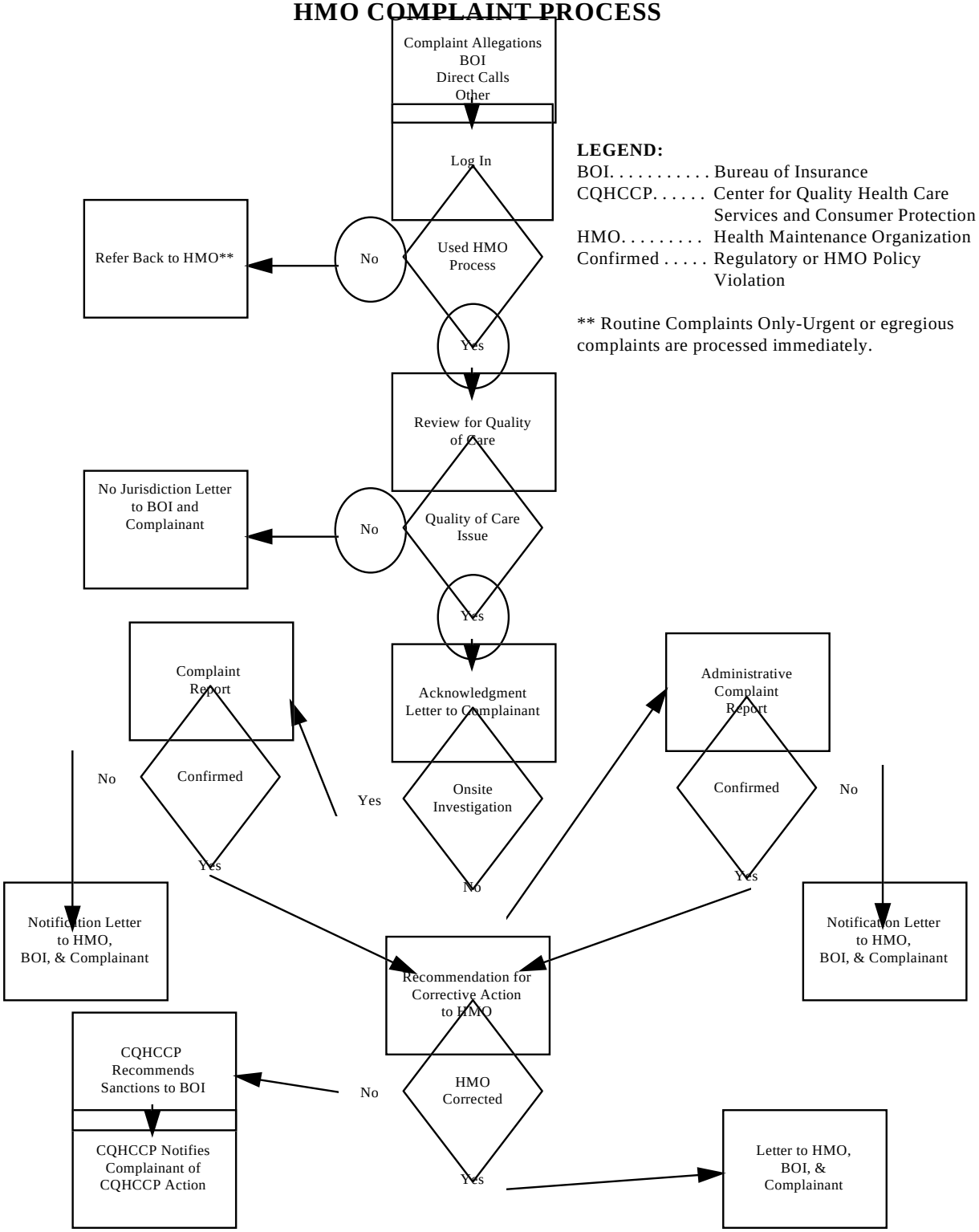
Denial of specialist referrals allowed within the contract
Denial of emergency room care allowed within the contract
Failure to adequately document and make available to the members reasons for denial
Unexplained death
Denial of care for serious injuries or illnesses, the natural history of which, if untreated, are likely to result in death or to progress to a more severe form
Organ transplant criteria questioned

PRACTITIONERS/PROVIDERS

Appropriateness of diagnosis and/or care
Appropriateness of credentials to treat
Failure to observe professional standards of care, state and/or federal regulations governing health care quality
Unsanitary physical environment
Failure to observe sterile techniques or universal precautions
Medical records - Failure to keep accurate and legible records, to keep them confidential and to allow patient access
Failure to coordinate care (Example: appropriate discharge planning)

The Center's expectation would be that HMO members had attempted to resolve their complaints initially by accessing the HMOs internal complaint resolution process and/or their employers' health benefits office prior to bringing their complaints to the Center unless the complaint was so urgent that it placed the patient or others in serious jeopardy.

## Appendix II
## The Center for Quality Health Care Services and Consumer Protection's
## HMO COMPLAINT PROCESS




**LEGEND:**
BOI. . . . . Bureau of Insurance
CQHCCP. . . . . Center for Quality Health Care Services and Consumer Protection
HMO. . . . . Health Maintenance Organization
Confirmed . . . . . Regulatory or HMO Policy Violation

** Routine Complaints Only-Urgent or egregious complaints are processed immediately.

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